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Research Report

Meditation for Depression

A Systematic Review of Mindfulness-Based Cognitive Therapy for Major Depressive Disorder

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RAND NSRD

RR-1138 -OSD

October 2015

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

Report Documentation Page		Form Approved OMB No. 0704-0188
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.		
1. REPORT DATE OCT 2015	2. REPORT TYPE	3. DATES COVERED 00-00-2015 to 00-00-2015
4. TITLE AND SUBTITLE Meditation for Depression: A Systematic Review of Mindfulness-Based Cognitive Therapy for Major Depressive Disorder		5a. CONTRACT NUMBER
		5b. GRANT NUMBER
		5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S)	5d. PROJECT NUMBER	
	5e. TASK NUMBER	
	5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) RAND Corporation,National Defense Research Institute,1776 Main Street, P.O. Box 2138,Santa Monica,CA,90407-2138		8. PERFORMING ORGANIZATION REPORT NUMBER
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)		10. SPONSOR/MONITOR'S ACRONYM(S)
		11. SPONSOR/MONITOR'S REPORT NUMBER(S)
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited		
13. SUPPLEMENTARY NOTES		

14. ABSTRACT

Depression is a prevalent psychological health condition and clinical diagnoses such as major depressive disorder (MDD) are associated with significant burden in terms of reduced quality of life, lower productivity, increased prevalence of other conditions and increased health care costs. Several meditation approaches including mindfulness-based cognitive therapy (MBCT) have shown promise in the treatment of depression and the prevention of relapse. We conducted a systematic review of randomized controlled trials (RCTs) that assessed the efficacy and safety of MBCT for the treatment of patients diagnosed with MDD. We searched the databases PubMed, CINAHL, PsycINFO, Web of Science, Embase, CDSR CENTRAL, DARE, clinicaltrials.gov, and PILOTS for English language RCTs published to January 2015. Two independent reviewers screened retrieved publications using a set of inclusion and exclusion criteria, abstracted study level data and assessed the quality of included studies. Meta-analysis was performed using the Hartung-Knapp-Sidik-Jonkman method for random-effects models. Quality of evidence was assessed using GRADE. Seventeen studies met inclusion criteria. Adjunctive MBCT reduced depressive symptoms compared to a mix of comparators in patients with MDD (SMD -0.77, 95% CI -1.21, -0.34; 7 RCTs) and in patients with MDD or a history of MDD (SMD -0.70; 95% CI -1.10, -0.29; 12 RCTs), but there was substantial heterogeneity. MBCT plus treatment as usual (TAU) reduced depressive symptoms more than TAU alone (SMD -0.92; -1.57, -0.27; 5 RCTs); based on two identified RCTs, MBCT compared to CBT without mindfulness meditation did not show statistically significant differences (SMD -0.06, 95% CI -1.01, 0.89; 2 RCTs). MBCT was more effective than other comparators, in particular TAU, in the prevention of relapse in patients with a history of MDD (RR 0.72; 95% CI 0.56, 0.93; 6 RCTs). Five RCTs addressed adverse events three reported no adverse events occurred, two reported adverse events that were deemed not related to the intervention. Differences in quality of life between MBCT and other interventions did not show statistically significant effects (SMD -0.46; 95% CI 0.97, 0.05; 5 RCTs) nor did the use of antidepressants (RR -0.01; 95% CI -0.34, 0.32; 5 RCTs). Very few studies assessed monotherapy MBCT and the evidence was insufficient to determine its effect. The MBCT evidence base is growing and data for relapse as well as depressive symptom reduction exist. MBCT is more effective than TAU alone but intervention-specific effects of MBCT, e.g., compared to CBT without mindfulness meditation components, have to be investigated further.

15. SUBJECT TERMS

16. SECURITY CLASSIFICATION OF:

a. REPORT

unclassified

b. ABSTRACT

unclassified

c. THIS PAGE

unclassified17. LIMITATION OF
ABSTRACT**Same as
Report (SAR)**18. NUMBER
OF PAGES**155**19a. NAME OF
RESPONSIBLE PERSON

Preface

Depression is a prevalent psychological health condition and clinical diagnoses such as major depressive disorder (MDD) are associated with significant burden for patients and society in terms of reduced quality of life, productivity, increased rates of other health conditions and increased health care costs. While several evidence-based treatments are included as front-line treatments for MDD in clinical practice guidelines, these interventions vary in their effectiveness, safety, and acceptability to different patient populations. Complementary and alternative medicine (CAM) approaches to MDD treatment are becoming more common and a number of military treatment facilities (MTFs) offer these services, including meditation therapies. However, the efficacy and effectiveness of meditation for the treatment of MDD remains unclear.

This report describes a systematic review of Mindfulness Based Cognitive Therapy in the treatment of MDD. Key questions guiding this work focused on the efficacy and effectiveness of meditation for improving MDD symptoms and quality of life, as well as describing the occurrence of adverse events related to meditation among MDD populations.

This report should be of interest to health care providers and clinical policy makers interested in the treatment of MDD or the use of meditation. This research was sponsored by the Office of the Secretary of Defense and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and conducted within the Forces and Resources Policy Center of the RAND National Defense Research Institute, a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community.

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Abstract

Depression is a prevalent psychological health condition and clinical diagnoses such as major depressive disorder (MDD) are associated with significant burden in terms of reduced quality of life, lower productivity, increased prevalence of other conditions and increased health care costs. Several meditation approaches including mindfulness-based cognitive therapy (MBCT) have shown promise in the treatment of depression and the prevention of relapse. We conducted a systematic review of randomized controlled trials (RCTs) that assessed the efficacy and safety of MBCT for the treatment of patients diagnosed with MDD.

We searched the databases PubMed, CINAHL, PsycINFO, Web of Science, Embase, CDSR, CENTRAL, DARE, clinicaltrials.gov, and PILOTS for English language RCTs published to January 2015. Two independent reviewers screened retrieved publications using a set of inclusion and exclusion criteria, abstracted study level data and assessed the quality of included studies. Meta-analysis was performed using the Hartung-Knapp-Sidik-Jonkman method for random-effects models. Quality of evidence was assessed using GRADE.

Seventeen studies met inclusion criteria. Adjunctive MBCT reduced depressive symptoms compared to a mix of comparators in patients with MDD (SMD -0.77, 95% CI -1.21, -0.34; 7 RCTs) and in patients with MDD or a history of MDD (SMD -0.70; 95% CI -1.10, -0.29; 12 RCTs), but there was substantial heterogeneity. MBCT plus treatment as usual (TAU) reduced depressive symptoms more than TAU alone (SMD -0.92; -1.57, -0.27; 5 RCTs); based on two identified RCTs, MBCT compared to CBT without mindfulness meditation did not show statistically significant differences (SMD -0.06, 95% CI -1.01, 0.89; 2 RCTs). MBCT was more effective than other comparators, in particular TAU, in the prevention of relapse in patients with a history of MDD (RR 0.72; 95% CI 0.56, 0.93; 6 RCTs). Five RCTs addressed adverse events; three reported no adverse events occurred, two reported adverse events that were deemed not related to the intervention. Differences in quality of life between MBCT and other interventions did not show statistically significant effects (SMD -0.46; 95% CI -0.97, 0.05; 5 RCTs) nor did the use of antidepressants (RR -0.01; 95% CI -0.34, 0.32; 5 RCTs). Very few studies assessed monotherapy MBCT and the evidence was insufficient to determine its effect.

The MBCT evidence base is growing and data for relapse as well as depressive symptom reduction exist. MBCT is more effective than TAU alone but intervention-specific effects of MBCT, e.g., compared to CBT without mindfulness meditation components, have to be investigated further.

Summary

Introduction

Depression is a prevalent psychological health condition and clinical diagnoses such as major depressive disorder (MDD) are associated with significant burden for patients and society in terms of reduced quality of life, lower productivity, increased prevalence of other conditions and increased health care costs. Meditation is a mind-body technique that refers to a broad variety of practices with the general goal of training the mind through regulation of attention and/or emotion to affect body functions, symptoms, and state of being. Meditation practice has recently been embedded in existing therapeutic approaches, in particular Mindfulness Based Cognitive Therapy (MBCT). MBCT is a standardized training program that combines cognitive therapy with the practice of mindfulness meditation. This review summarizes the current state of the evidence from randomized controlled trials (RCTs) testing the efficacy and safety of MBCT for patients diagnosed with MDD.

Methods

To address our Key Questions, we conducted a systematic search of databases (PubMed, CINAHL, PsycINFO, Web of Science, Embase, CDSR, DARE, clinicaltrials.gov, and PILOTS) for English language RCTs published to January 2015 testing the efficacy and safety of the meditation intervention MBCT, either as monotherapy or as adjunctive therapy, to treat adults with MDD or to prevent relapse of MDD. In addition, we screened bibliographies of prior systematic reviews and included studies.

Two independent reviewers used pre-established eligibility criteria to screen identified studies, abstract study-level information, and assess the quality of included studies. Outcomes of interest included depressive symptoms, relapse, health-related quality of life and adverse events. Meta-analysis was performed with the Hartung-Knapp-Sidik-Jonkman method for random-effects models, a method suitable when the number of pooled studies is small and there is evidence of heterogeneity. The quality of evidence was assessed using the GRADE approach.

Results

A total of 17 studies met the inclusion criteria for our review.

Key Question 1. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with MDD?

We did not identify any study in patients with a current diagnosis of MDD that reported on the effectiveness of MBCT offered as monotherapy.

We identified one study in patients in full or partial remission that explicitly assessed MBCT as monotherapy and reported on depressive symptoms. The study reported a significantly greater reduction in depressive symptoms compared to waitlist (SMD -1.11; 95% CI -2.07, -0.15; 1 RCT).

Given the paucity of relevant studies we cannot sufficiently answer the review question.

Key Question 1a. Among publications that address monotherapy meditation as a treatment for adults with MDD, how common and severe are adverse events?

Only two studies explicitly assessed MBCT as monotherapy. One of the studies addressed adverse events and reported that none occurred; the other study did not report on adverse events.

Key Question 1b. Does the efficacy differ depending on the characteristics of meditation used?

There was insufficient information to determine whether the efficacy differs depending on the type of meditation used.

Key Question 2. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with MDD?

Seven RCTs reported on depressive symptoms in adults with current MDD. There was moderate quality evidence of MBCT reducing depressive symptoms in patients with MDD compared to all comparators (SMD -0.77, 95% CI -1.21, -0.34; I^2 63%; 7 RCTs).

Twelve RCTs examined adjunctive MBCT on depressive symptom scores. There was moderate evidence in support of the use of adjunctive MBCT overall interventions (SMD -0.72, 95% CI -1.14, -0.30; I^2 85%; 12 RCTs). There was moderate evidence of its efficacy compared to TAU (SMD -0.92, 95% CI -1.57, -0.27; I^2 80%; 5 RCTs). The evidence suggested that MBCT had no significant effect on residual depressive symptom scores among those with a history of depression, but not currently depressed (SMD -0.57, 95% CI -1.67, 0.53; I^2 92%; 5 RCTs).

Key Question 2a. Among publications that address adjunctive meditation as a treatment for adults with MDD, how common and severe are adverse events?

Five out of 15 studies addressed adverse events. Of those, three reported that none occurred. One study reported that the adverse events were not related to the intervention; another study reported two adverse events, one of which occurred in the intervention arm of the study.

Key Question 2b. Does the efficacy differ depending on the type meditation used?

There was insufficient evidence to answer this question. A meta-regression analyzing differences between studies following the original MBCT manual versus studies that used a modified MBCT intervention indicated deviations were not significantly associated with MBCT results. In individuals with recurrent depression, one study found a weak correlation between the amount of formal meditation practiced outside the class and change in depressive symptom score during MBCT.

Key Question 3. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with MDD?

Only one study assessed whether monotherapy MBCT reduces relapse rates compared to two control groups: 1) antidepressants and 2) placebo plus clinical management in a sample in remission with a history of at least three previous episodes of depression. Overall, there were no significant differences in relapse rates between either MBCT and antidepressants (RR=0.80, 95% CI [0.39, 1.62]) or between monotherapy MBCT and placebo plus clinical management (RR=0.65, 95% CI [0.34, 1.62]). Thus, there is insufficient evidence to draw any conclusions on this question.

Key Question 3a. Does the efficacy differ depending on the type meditation used?

There was insufficient evidence to answer this question.

Key Question 4. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with MDD?

We identified no study in adults with MDD that reported long-term effects. Six studies addressed MBCT as an adjunct treatment that included an assessment of relapse. There was moderate quality evidence that adjunctive MBCT reduces relapse rates compared to all controls (RR 0.72; 95% CI [0.56, 0.93]; I^2 25%; 6 RCTs) and compared to TAU (RR 0.70; 95% CI 0.50, 0.98; I^2 39%; 5 RCTs). Among patients with at least three prior episodes of depression in at least partial recovery, there was moderate evidence of the impact of adjunctive MBCT on relapse rates (RR=0.66, 95% CI [0.48, 0.90] I^2 47%, 6 RCTs). However, the evidence does not support that

MBCT reduces relapse rates among individuals with one or two previous depressive episodes (RR =1.96, 95% CI [0.31, 12.29] I^2 0%; 2 RCTs).

Key Question 4a. Does the efficacy differ depending on the type meditation used?

There was insufficient evidence to answer this question. A meta-regression analyzing differences between studies following the original MBCT manual versus studies that used a modified MBCT intervention indicated deviations were not significantly associated with relapse. A study of individuals with recurrent depression found relapse rates were higher among individuals with more body scan practice six to twelve months after MBCT, but found no associations with other forms of practice. Another study of individuals with recurrent depression found no difference in relapse rates between two trained MBCT instructors of different backgrounds.

Key Question 5. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving health-related quality of life (HR-QOL) in adults with MDD?

We did not identify any study that assessed whether monotherapy MBCT was associated with improved health-related quality of life among adults with MDD.

Key Question 6. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving HR-QOL in adults with MDD?

Five studies examined the effect of adjunctive MBCT on HR-QOL; TAU was the only comparator used in more than one study. Overall, there was very low quality evidence of the effect of MBCT on HR-QOL. The pooled estimate showed no significant differences in quality of life in the MBCT groups compared to control (SMD -0.42; 95% CI -0.70, -0.14; I^2 71%; 5 RCTs).

Key Question 7. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with MDD?

No studies addressed this question.

Key Question 8. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with MDD?

Six studies of good and fair quality were identified that examined the impact of adjunctive MBCT on antidepressant use or antidepressant costs. The pooled estimate of the four studies that

examined use showed no statistically significant differences in antidepressant use in the MBCT groups compared to control (RR -0.01; 95% CI -0.34, 0.32; I^2 18%; 4 RCTs). A fifth study found no statistically significant differences in changes in antidepressant use and the sixth study focused on costs. There is moderate evidence that MBCT does not affect antidepressant use.

Conclusions

The evidence supports the use of adjunctive MBCT to reduce depressive symptoms among those currently depressed. The evidence also supports the use of adjunctive MBCT to reduce relapse among those with a history of at least three previous depressive episodes, but not among those with a previous history of one or two previous depressive episodes. This issue warrants additional research.

There is insufficient evidence on the use of monotherapy MBCT to draw conclusions about its efficacy, either to reduce depressive symptoms among those currently depressed or among those with a history of depression to reduce relapse. These are areas where additional studies are needed. There is also insufficient evidence on the effect of MBCT on HR-QOL. Few studies examined the effect of MBCT on measures of HR-QOL and there was a lack of consistency in comparators used and the measures HR-QOL included. Further exploration of this is warranted.

The reported occurrence of adverse events was infrequent and did not appear to be related to MBCT. However, only six of the included studies (one monotherapy and five adjunctive) reported on adverse events.

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Acknowledgements

We gratefully acknowledge the assistance of Jody Larkin, the research librarian who conducted the literature searches, and Reema Singh and Barbara Hennessey who provided administrative support, technical support, and other assistance in conducting the literature review and preparing the technical report. We are grateful to Dr. Kristie Gore for her support and guidance throughout the project. Thank you also to our project officers and points of contact at the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, Dr. Mark Bates, Dr. Chris Crowe, Dr. Marina Khusid, Dr. Katherine McGraw, and CDR Angela Steele and for their support of our work. In addition, we thank Dr. Susanne Hempel and Dr. Greg Serpa for reviewing the report and their helpful suggestions. Any errors of fact or interpretation in this report remain the responsibility of the authors.

Abbreviations

BDI	Beck Depression Inventory
CAM	Complementary and alternative medicine
CBT	Cognitive behavioral therapy
CCMD-3	Chinese Classification and Diagnostic Criteria of Mental Disorders, 3 rd edition
CES-D	Center for Epidemiologic Studies - Depression Scale
CINAHL	Cumulative Index to Nursing and Allied Health Literature
DARE	Database of Abstracts of Reviews of Effects
DCoE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPDS	Edinburgh Postnatal Depression Scale
GRADE	Grades of Recommendation, Assessment, Development, and Evaluation
HRQOL	Health-related quality of life
HRSD	Hamilton Rating Scale for Depression
ICD	International Classification of Diseases
ISI	Insomnia Severity Index
MBCT	Mindfulness-based cognitive therapy
MDD	Major depressive disorder
PICOTSS	Populations, Interventions, Comparators, Outcomes, Timing, Setting, Study design
PSQI	Pittsburgh Sleep Quality Index
RCT	Randomized control trial
RR	Relative risk
SMD	Standardized mean difference
TCM	Traditional Chinese Medicine

1. Introduction

Major depressive disorder is a prevalent condition associated with significant burden for patients and society in terms of reduced quality of life, productivity, increased rates of other health conditions and increased health care costs. In the general population of the United States, epidemiological studies of major depressive disorder (MDD) suggest lifetime prevalence estimates between 13 and 16 percent and 12-month prevalence estimates between five and seven percent among adults (Hasin, Goodwin, Stinson et al., 2005; Kessler, Berglund, Demler et al., 2003). Military service members and veterans with a history of combat exposure in the context of a deployment have been found to have elevated rates of probable MDD relative to the general population (Hoge, Castro, Messer et al., 2004; Schell and Marshall, 2008; Vaughan, Schell, Jaycox et al., 2011; Wells, Mann, Fortuna et al., 2010). Although the majority of individuals who develop MDD will experience remission within a year of onset of the major depressive episode (Coryell, Akishal, Leon et al., 1994; Spijker, de Graaf, Bijl et al., 2002), the probability of experiencing a recurrent episode is high. Roughly 80 percent of individuals who experience one episode of depression will experience another episode in the future (Judd, 1997). MDD is associated with significant medical, social and economic consequences, including increased risk of various physical conditions, relationship problems, lost productivity, and health care costs (Donohue and Pincus, 2007; Kessler, 2012).

Several evidence-based treatments for MDD exist and are highlighted as front-line treatments for MDD in the Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guidelines for the Management of MDD (The Management of MDD Working Group, 2009). However, these interventions vary in their effectiveness, safety, and acceptability to different patient populations, and many individuals who would benefit from treatment do not receive depression-related care (Tylee and Jones, 2005). The literature has documented a wide variety of barriers to mental health care among military personnel and veterans, including stigma, beliefs about mental health and mental health treatment, and access to mental health providers (Ben-Zeev, Corrigan, Britt et al., 2012; Vogt, 2011; Zinzow, Britt, McFadden et al., 2012). Individuals with depression may use complementary and alternative medicine therapies (Kessler, Soukup, Davis et al., 2001). One popular type of complementary and alternative medicine (CAM) treatment that has been used in the treatment of MDD is meditation (Su and Lifeng, 2011). Meditation is a mind-body technique that refers to a broad variety of practices with the general goal of training the mind through regulation of attention and/or emotion to affect body functions, symptoms, and state of being (National Center for Complementary and Alternative Medicine (NCCAM), 2005; Nash and Newberg, 2013; National Center for Complementary and Alternative Medicine (NCCAM), 2001). Meditation practice can also be

embedded in a broader approach that includes movement (e.g., yoga, tai chi), i.e., movement meditation (Cahn and Polich, 2006; Goyal, Singh, Sibinga et al., 2014).

The only form of meditation specifically addressed in the current VA/DoD Clinical Practice Guideline on the Management of Major Depressive Disorder is mindfulness based cognitive therapy (MBCT), which is a standardized training program that combines the principles of cognitive therapy with the practice of mindfulness meditation. The guideline indicates that MBCT may be employed for patients at high risk of relapse during the treatment continuation phase and comments on the lack of research comparing mindfulness-based interventions to control groups, medication, and psychotherapy during initial treatment (The Management of MDD Working Group, 2009).

This review seeks to examine the current state of the evidence regarding the efficacy and effectiveness of MBCT for MDD.

Key Questions

We conducted a systematic review to identify randomized control trials (RCTs) testing the efficacy and safety of meditation to treat individuals with MDD. Specifically, this systematic review aimed to answer the following key questions and sub-questions:

Primary Key Questions

1. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with MDD?
 - a. Among publications that address monotherapy meditation as a treatment for adults with MDD, how common and severe are adverse events?
 - b. Does the efficacy differ depending on the type meditation (e.g., MBCT, MBSR, yoga, tai chi) used?
2. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with MDD?
 - a. Among publications that address adjunctive meditation as a treatment for adults with MDD, how common and severe are adverse events?
 - b. Does the efficacy differ depending on the type meditation used?
3. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse¹ rates in adults with MDD?

¹ A relapse occurs when a patient previously in remission experiences another episode of major depressive disorder less than a year after the previous episode; a recurrence occurs when a patient experiences a subsequent episode of major depression at least a year after the previous episode. Here we use the term relapse to include both relapses and recurrences.

- a. Does the efficacy differ depending on the type meditation used?
- 4. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with MDD?
 - a. Does the efficacy differ depending on the type meditation used?

Secondary Key Questions

- 5. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving health-related quality of life (HRQOL) symptoms in adults with MDD?
- 6. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving HRQOL symptoms in adults with MDD?
- 7. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with MDD?
- 8. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with MDD?

2. Methods

Search strategy

We searched the databases PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), PsycINFO, Web of Science, Embase, SDR and CENTRAL (the Systematic Reviews and Trials databases of the Cochrane library), DARE (Database of Abstracts of Reviews of Effects), and PILOTS (Published International Literature on Traumatic Stress) for studies published to January 2015. In addition, we also screened studies included in prior systematic reviews related to this topic. Clinicaltrials.gov also was searched and authors of all relevant, completed trials for which published data were not available were contacted to invite the submission of in-press publications.

The search strategy was developed by a Reference Librarian for RAND's Knowledge Services informed by search results of existing reviews. The search strings are described in Appendix A.

Eligibility criteria

The inclusion and exclusion criteria we applied to retrieved publications can be summarized in the following "PICOTSS" framework of participants, interventions, comparators, outcomes, timing, settings, and study design.

- **Participants:** Studies were limited to those that focused on adults, male and female, who are at least 18 years of age and have been diagnosed with MDD. MDD was defined as meeting the criteria for a clinical diagnosis of MDD according to the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) or International Classification of Diseases (ICD; Department of Health and Human Services, 2002) criteria. We included studies of populations with a history of MDD if they reported data on depressive symptoms or relapse.
- **Interventions:** Studies were included that examined the effect of MBCT. We included studies reporting deviations from the original MBCT protocol (Segal et al. 2002) if MBCT was clearly referred to.
- **Comparators:** Studies that utilized treatment as usual (TAU), wait-list control, attention control, no treatment, or other active treatments as the comparator were included. Studies that exclusively compared MBCT to other forms of complementary and alternative medicine (e.g., acupuncture) were excluded.
- **Outcomes:** Studies that reported one or more of the following outcomes were included: depression symptoms, treatment response, remission, relapse/recurrence, and health-

related quality of life.

- Timing: Studies could involve any treatment duration and follow-up period.
- Setting: Studies were not limited by setting.
- Study Design: Included studies were limited to individually- or cluster-randomized controlled trials only.
- Other limiters: Studies had to be published in English to be eligible. Data reported only in conference proceedings or abstracts were excluded.

Inclusion screening

Two independent reviewers screened titles and abstracts of retrieved citations following a pilot exercise to ensure similar interpretation of the inclusion and exclusion criteria. Citations judged to be potentially eligible by at least one reviewer were obtained as full text. Two independent reviewers screened full text studies against predefined inclusion and exclusion criteria, any disagreements between the reviewers were resolved through discussion within the review team. The flow of citations throughout this process was documented in an electronic database, and reasons for exclusion of publications that underwent full-text screening were recorded in the database.

Data extraction

Each publication was abstracted by two reviewers using electronic data collection forms designed by the project lead, with input from the project team. Reviewers pilot tested the data collection forms on a few well-reported studies, modified the forms, and performed a final pilot of the forms on a random selection of included studies to ensure agreement of interpretation. The reviewers then independently abstracted study-level data in an electronic database. All discrepancies were resolved by PhD-level staff with input from both reviewers in a group setting.

Study-level data was abstracted for the following information:

- Participants: gender, age, method of depression identification, baseline depression scores;
- Interventions: type of meditation, dosage (intensity, frequency, duration), and co-intervention(s);
- Comparators: type of comparator;
- Outcomes (depressive symptoms score, response to treatment², remission, relapse, health related quality of life, adverse events), for each follow-up point of measurement: domain, method of measurement, metric of data expression (e.g., means, proportions);
- Timing: timing of outcome assessment(s); and
- Country where the trial occurred.

² Response to treatment is at least a 50 percent reduction in the Hamilton Rating Scale for Depression (HRSD) score.

- Study design, purpose, inclusion and exclusion criteria, starting and ending sample size, items relevant to risk of bias and quality ratings

When different reports existed for the same study, descriptions of participants were compared to ensure that data from the same study populations are included in the review only once.

Risk of bias

Project leaders assessed the risk of bias of included RCTs using the Cochrane Risk of Bias tool (Higgins, Altman, Gøtzsche et al., 2011). Specifically, the reviewers assessed risk of bias related to the following: random sequence generation (selection bias), allocation concealment (selection bias), blinding of participants (performance bias), blinding of outcome assessors (detection bias), completeness of reporting outcome data (attrition bias), and selective outcome reporting (reporting bias). Other biases related to the US Preventive Services Task Force's criteria for internal validity of included studies were also assessed, namely those related to: equal distribution amongst groups of potential confounders at baseline; cross-overs or contamination between groups; equal, reliable, and valid outcome measurement; clear definitions of interventions; and intention-to-treat analysis (US Preventive Services Task Force, 2008). These criteria were used to rate the quality of evidence of individual included studies using the following guidelines (The Lewin Group and ECRI Institute, 2014; US Preventive Services Task Force, 2008):

- **Good:** Comparable groups are initially assembled and maintained throughout the study with at least 80 percent follow-up; reliable, valid measurement is used and applied equally to all groups; interventions are clearly described; all important outcomes are considered; appropriate attention is given to confounders in analysis; intention-to-treat analysis is used.
- **Fair:** One or more of the following issues is found in the study: some though not major differences between groups exist at follow-up; measurement instruments are acceptable but not ideal, though are generally applied equally; some but not all important outcomes are considered; some but not all potential confounders are account for in analyses. Intention-to-treat analysis is used.
- **Poor:** One or more of the following “fatal flaws” is found in the study: initially assembled groups are not comparable or maintained throughout the study; unreliable or invalid measurements are used or applied unequally across groups; key confounders are given little to no attention in analyses; intention-to-treat analysis is not used.

Data synthesis

The primary aim of this systematic review was to identify whether meditation in the format of MBCT is effective in improving MDD symptoms and can prevent relapse. A secondary outcome was adverse events. Results are described separately for MBCT delivered as

monotherapy versus adjunctive therapy. We differentiated patients who had a clinical diagnosis of MDD, were experiencing a depressive episode, or had residual symptoms when they enrolled in the study and patients with prior MDD, but in remission.

Treatment effects for continuous outcomes were computed as standardized mean differences (SMD) together with their 95 percent confidence intervals (CI) to ensure comparability of effect sizes across studies using different outcome measures. Relative risks (RR) were computed for dichotomous variables (i.e., relapse). Results are reported such that SMD less than zero and (RR) less than one favors MBCT.

We used meta-analysis to pool results across included studies for depressive symptoms, relapse and HR-QOL. We used the Hartung- Knapp-Sidik-Jonkman method for random effects models (Hartung, 1999; Hartung and Knapp, 2001; Sidik and Jonkman, 2007). This method may be preferred when the number of studies pooled is small and when there is evidence of heterogeneity (IntHout, Ioannidis and Borm, 2014). It produces more robust error rates than the DerSimonian and Laird method (Sánchez-Meca and Marín-Martínez, 2008).

We calculated treatment effects at post-intervention or the closest follow-up point to post-intervention reported in the individual studies. When multiple depression measures were available, we used Hamilton Depression Rating Scale (HAMD) scores to assess treatment effects on depression symptoms followed by the Beck Depression Inventory (BDI). When multiple HQ-QOL domains were reported, we used the psychological domain (rather than physical or social). Outcome data were based on intention to treat (ITT) analyses reported in the included studies. In the absence of ITT data, we used the number of patients at follow-up. When studies reported on more than one comparator, the pooled analyses used a passive comparator where possible (e.g., waitlist, TAU). We also investigated publication bias for all main analyses with sufficient data using Begg's rank correlation test for funnel plot asymmetry (Begg and Mazumdar, 1994) and Egger's test for funnel plot asymmetry (Egger et al., 1997).

Subgroup analyses grouped studies by comparator. Meta-regression was used to determine the effect of effect modifiers.

Quality of evidence

The quality of evidence was assessed for major outcomes using the GRADE approach in which the body of evidence was assessed based on the following dimensions: study limitations, directness, consistency, and precision:

The quality of evidence was graded on a 4-point scale:

- **High** indicates that the review authors are very confident that the effect estimate lies close to the true effect for a given outcome, as the body of evidence has few or no deficiencies. As such, the reviewers believe the findings are stable: i.e., further research is very unlikely to change confidence in the effect estimate.
- **Moderate** indicates that the review authors are moderately confident that the effect estimate lies close to the true effect for a given outcome, as the body of evidence has

some deficiencies. As such, the reviewers believe that the findings are likely to be stable, but further research may change confidence in the effect estimate and may even change the estimate.

- **Low** indicates that the review authors have limited confidence that the effect estimate lies close to the true effect for a given outcome, as the body of evidence has major or numerous (or both) deficiencies. As such, the reviewers believe that additional evidence is needed before concluding either that the findings are stable or that the effect estimate lies close to the true effect.
- **Very low** indicates that the review authors have very little confidence that the effect estimate lies close to the true effect for a given outcome, as the body of evidence has very major deficiencies. As such, the true effect is likely to be substantially different from the estimated effect; thus, any estimate of effect is very uncertain.

Protocol deviations

In order to provide more targeted information to answer the review questions we did not apply the depression scale cut offs as described in the systematic review protocol, but limited included studies to those that reported a clinical diagnosis of MDD. An initial screen of the identified literature indicated substantial clinical diversity; depression is a symptom relevant to a number of mental disorders, patient characteristics vary, and it is unclear whether and how treatment effects will translate to patients with MDD.

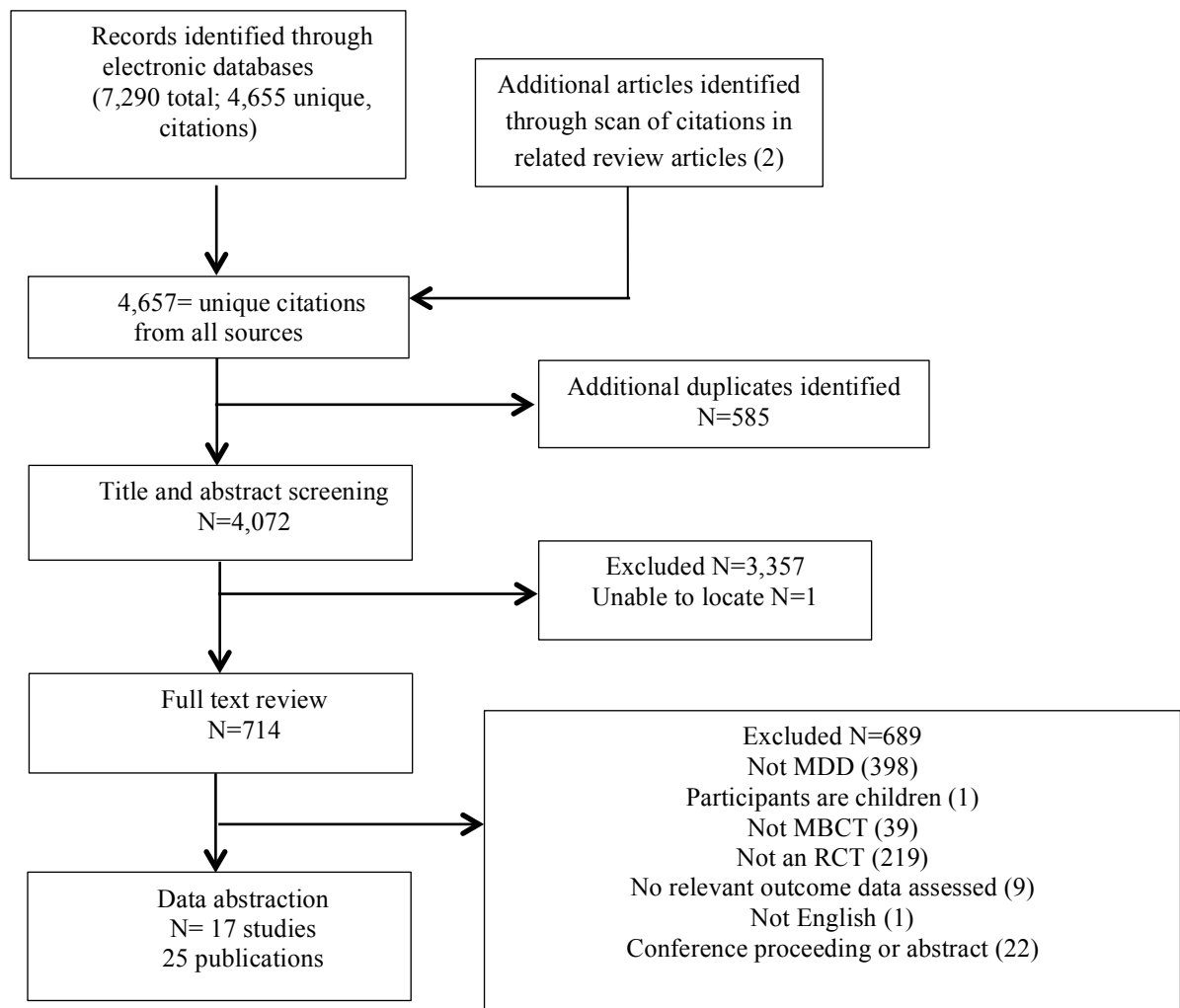
In addition, we restricted the systematic review to MBCT in order to be able to provide clear effectiveness statements. The initial searches indicated that the effect of other interventions such as person-based cognitive therapy, compassion-mindfulness therapy, mindfulness meditation, mantra meditation, mindfulness training, miscellaneous group meditation formats, Chan-based mind-body intervention, Buddhist walking meditation, tai chi, diverse yoga approaches, or qigong interventions have only been investigated in a very small number of studies in patients with a clinical diagnosis of MDD. Furthermore, test searches indicated that for each known intervention, due to the lack of standardization of the intervention description, including the name of the intervention (e.g., “tai chi,” tai-chi,” “tai ji,” “tai-ji,” “taiji,” “t’ ai chi,” “t’ ai chi,” “taijiquan,” OR “shadow boxing”), multiple searches in multiple sources would need to be undertaken in order to ensure that all relevant studies have been found. Meditation is an element in a variety of very diverse approaches, which requires extensive and exhaustive literature searches and multiple systematic reviews are necessary to summarize the effect of each of the diverse existing meditation interventions, which exceeds the resources of this project.

3. Results

Results of literature search

Our search of the electronic databases identified 7,290 publications; two additional studies were found through scanning citations (see Figure 3.1). After duplicates were removed, 4,072 publications were included for title and abstract screening, of which 3,357 were excluded because one or more of the exclusion criteria were met. An additional 690 were excluded during full text review (listed in Appendix B). A total of 25 publications describing 17 unique RCTs of MBCT were identified and met the inclusion criteria for our review (described in Table 3.1).

Figure 3.1: Publication Review and Inclusion



Description of studies by key question

For Key Question 1 on the effect of MBCT as monotherapy for depressive symptoms, we identified one RCT that reported on the effect of treatment on depressive symptoms using standardized scales (Britton, Haynes, Fridel et al., 2010). The study did not examine response to treatment (i.e., at least a 50 percent reduction in depressive symptom score on a standardized scale) or remission.

For Key Question 1a, one study provided information on the frequency and severity of adverse events that occurred with monotherapy MBCT (Britton et al., 2010).

For Key Question 2 on the effect of MBCT as adjunctive therapy for depressive symptoms, we identified 12 RCTs³ that reported depressive symptom scores using standardized scales (Barnhofer, Crane, Hargus et al., 2009; Batink, Peeters, Geschwind et al., 2013; Bondolfi, Jermann, der Linden et al., 2010; Chiesa, Mandelli and Serretti, 2012; Forkmann, Wichers, Geschwind et al., 2014; Geschwind, Peeters, Huibers et al., 2012; Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Jermann, Van der Linden, Gex-Fabry et al., 2013; Keune, Bostanov, Hautzinger et al., 2011a; Kuyken, Byford, Taylor et al., 2008; Ma and Teasdale, 2004; Manicavasgar, Parker and Perich, 2011; Omid, Mohammadkhani, Mohammadi et al., 2013; Shahar, Britton, Sbarra et al., 2010; van Aalderen, Donders, Gionni et al., 2012;). One study examined response to treatment (Barnhofer, Crane, Hargus et al., 2009).

For Key Question 2a, we found six studies that provided information on the frequency and severity of adverse events with adjunctive MBCT used to treat MDD (Barnhofer et al., 2009; Forkmann et al., 2014; Geschwind et al., 2012; Kuyken et al., 2008; Shahar et al., 2010; Williams, Crane, Barnhofer et al., 2014).

For Key Question 3, we identified one RCT that examined relapse after monotherapy MBCT (Segal, Bieling, Young et al., 2010), and for Key Question 4 we identified six studies that examined relapse after adjunctive MBCT (Godfrin and van Heeringen, 2010; Jermann et al., 2013; Kuyken et al., 2008; Ma and Teasdale, 2004; Teasdale, Segal, Williams et al., 2000; Williams et al., 2014).

We found no monotherapy MBCT studies that provided information on health related quality of life for Key Question 5. For Key Question 6, we found five adjunctive MBCT studies that provided information on health-related quality of life (Chiesa, Mandelli and Serretti, 2012; Godfrin and van Heeringen, 2010; Kuyken et al., 2008; Lavretsky and Irwin, 2010; Manicavasgar, Parker and Perich, 2011; van Aalderen et al., 2012).

We did not identify any RCTs that assessed reductions in antidepressant use following monotherapy MBCT (Key Question 7), but did identify six RCTs that investigated antidepressant use or costs of antidepressants for adjunctive MBCT (Key Question 8)

³ The number of citations may be larger than the number of RCTs identified. This occurs when more than one publication on the same RCT reported relevant and unique analyses to the review.

(Barnhofer, Crane, Hargus et al., 2009; Bondolfi, Jermann, der Linden et al., 2010; Godfrin and van Heeringen, 2010; Kuyken et al., 2008; Ma and Teasdale, 2004; Teasdale et al., 2000).

Table 3.1: Evidence Base for Key Questions

Question Number	Question	Number of Studies
1	Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with major depressive disorder?	1 RCT of monotherapy MBCT with efficacy data
1a	Among publications that address monotherapy meditation as a treatment for adults with major depressive disorder, how common and severe are adverse events?	1 RCT of monotherapy MBCT with safety data
1b	Does the efficacy of monotherapy meditation differ depending on the characteristics of meditation?	1 RCT of monotherapy MBCT with efficacy data
2	Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with major depressive disorder?	12 adjunctive MBCT with efficacy data
2a	Among publications that address adjunctive meditation as a treatment for adults with major depressive disorder, how common and severe are adverse events?	5 RCTs adjunctive MBCT with safety data
2b	Does the efficacy of adjunctive meditation differ depending on the type of meditation?	12 adjunctive meditation with efficacy data
3	Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with major depressive disorder?	1 RCT of monotherapy MBCT with relapse data
3a	Does the efficacy of monotherapy meditation differ depending on the type of meditation?	1 RCT of monotherapy MBCT with relapse data
4	Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with major depressive disorder?	6 RCTs adjunctive MBCT with relapse data
4a	Does the efficacy of adjunctive meditation differ depending on the type of meditation?	6 RCTs adjunctive MBCT with relapse data
5	Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving health-related quality of life in adults with major depressive disorder?	0 RCTs of monotherapy MBCT with health-related quality of life data
6	Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving health-related quality of life in adults with major depressive disorder?	5 RCTs adjunctive MBCT with health-related quality of life data
7	Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with major depressive disorder?	0 RCTs of monotherapy MBCT with antidepressant use
8	Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with major depressive disorder?	6 RCTs of adjunctive MBCT with antidepressant use

Description of studies by design

Nine RCTs randomized using a block randomization design, seven randomized individual participants rather than clusters of participants, and one study assigned participants to groups and

randomized the groups. The studies included in this review varied widely in size, ranging from 18 to 274 enrolled participants. Four RCTs included fewer than 50 participants; seven enrolled between 50 and 100 participants; five included 100 to 200 participants and two studies enrolled over 200 participants. Six reported an a priori power calculation with a target sample size, nine studies reported insufficient power for post-hoc analyses and two studies did not report information about power. Fifteen studies were two-arm RCTs, while two were three-arm RCTs.

Description of studies by location

The studies were performed in a variety of countries; two in the United States, five in the United Kingdom, two in the Netherlands, and one in each of the following countries: Australia, Belgium, Canada, Germany, Iran, Italy, and Switzerland. One study had sites in both Canada and the United Kingdom.

Description of studies by participants

The average age of participants ranged from 32 to 49 years in the studies that reported patient characteristics. One study did not report information about age of participants. The proportion of men in the studies ranged from 16 to 37 percent.

Description of studies interventions

Studies occurring after 2002 reported using the MBCT manual developed by Segal and colleagues (Segal et al. 2002). While all reported having eight weekly sessions, the length of the sessions varied from two to three hours. Studies reported holding up to four follow-up sessions after the completion of the MBCT intervention. Three studies reported modifying the MBCT program. Two made adjustments to address suicidality and acute symptoms (Barnhofer et al 2009; Williams et al., 2014). One study removed the yoga component (Manicavasgar et al. 2011).

Description of studies by comparators

Comparators in the studies varied. Monotherapy studies used waitlist, antidepressants, and antidepressant placebo plus clinical management as comparators. For adjunctive MBCT studies, the most common comparators were TAU (ten studies) and antidepressants (four studies) controls.

Description of studies by outcome measures

The length of follow-up ranged from immediately post-intervention to 15 months after treatment was completed. Thirteen studies reported depressive symptom scores as an outcome. Seven of the studies assessed relapse. Five studies reported measures of health-related quality of life. Seven studies reported adverse events or side effects.

Risk of bias in included studies

Table 3.2 summarizes the authors' assessment of the risk of bias for the included studies using the Cochrane Risk of Bias tool for RCTs. Four studies were assigned a "good" quality rating (Barnhofer et al., 2009; Bondolfi et al., 2010; Ma and Teasdale, 2004; Teasdale et al., 2000), five studies were rated "fair" quality (Chiesa, Mandelli and Serretti, 2012; Geschwind et al., 2012; Godfrin and van Heeringen, 2010; Kuyken et al., 2008; Segal et al., 2010), and eight studies were rated poor quality (Britton et al., 2010; Hepburn, Crane, Barnhofer et al., 2009; Keune et al., 2011a; Manicavasgar, Parker and Perich, 2011; Omid et al., 2013; Shahar et al., 2010; van Aalderen et al., 2012; Williams et al., 2014). In addition, seven studies had an overall rating of poor because of a lack of intention-to-treat (ITT) analysis.

Random sequence generation. Two studies had unclear selection bias because they did not report their method for randomizing study participants (Hepburn, Crane, Barnhofer et al., 2009; Omid et al., 2013). Of the remaining studies, 14 were rated as low risk as they reported adequate random sequence generation methods (Barnhofer et al., 2009; Bondolfi et al., 2010; Britton et al., 2010; Chiesa, Mandelli and Serretti, 2012; Geschwind et al., 2012; Godfrin and van Heeringen, 2010; Keune, Bostanov, Hautzinger et al., 2011b; Kuyken et al., 2008; Ma and Teasdale, 2004; Segal et al., 2010; Shahar et al., 2010; Teasdale et al., 2000; van Aalderen et al., 2012; Williams et al., 2014).

Allocation concealment. Five studies had unclear selection bias because they did not report their allocation concealment method (Chiesa, Mandelli and Serretti, 2012; Hepburn, Crane, Barnhofer et al., 2009; Kuyken et al., 2008; Omid et al., 2013; van Aalderen et al., 2012). Twelve other studies did describe their method of allocation concealment and were rated as low risk (Barnhofer et al., 2009; Bondolfi et al., 2010; Britton et al., 2010; Forkmann et al., 2014; Geschwind et al., 2012; Godfrin and van Heeringen, 2010; Jermann et al., 2013; Keune et al., 2011b; Ma and Teasdale, 2004; Manicavasgar, Parker and Perich, 2011; Segal et al., 2010; Shahar et al., 2010; Teasdale et al., 2000; Williams et al., 2014).

Blinding of participants. Two studies had unclear selection bias because they did not report the approach for ensuring blinding of participants (Chiesa, Mandelli and Serretti, 2012; Omid et al., 2013). Fifteen studies did not report adequate blinding approaches and were rated as high risk (Barnhofer et al., 2009; Bondolfi et al., 2010; Britton et al., 2010; Forkmann et al., 2014; Geschwind et al., 2012; Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Jermann et al., 2013; Keune et al., 2011b; Kuyken et al., 2008; Ma and Teasdale, 2004; Manicavasgar, Parker and Perich, 2011; Segal et al., 2010; Shahar et al., 2010; Teasdale et al., 2000; van Aalderen et al., 2012; Williams et al., 2014).

Blinding of outcome assessors. Three studies had unclear risk of detection bias because they did not report whether outcome assessors were blind to participation allocation to study arms (Manicavasgar, Parker and Perich, 2011; Omid et al., 2013; van Aalderen et al., 2012). Fourteen studies reported the outcome assessors were blinded to intervention assignment or the study

outcomes were self-reported instruments and were low risk (Barnhofer et al., 2009; Bondolfi et al., 2010; Britton et al., 2010; Chiesa, Mandelli and Serretti, 2012; Forkmann et al., 2014; Geschwind et al., 2012; Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Jermann et al., 2013; Keune et al., 2011a; Kuyken et al., 2008; Ma and Teasdale, 2004; Segal et al., 2010; Shahar et al., 2010; Teasdale et al., 2000; Williams et al., 2014).

Incomplete outcome data. Seven studies had low risk of attrition bias (Barnhofer et al., 2009; Bondolfi et al., 2010; Forkmann et al., 2014; Geschwind et al., 2012; Jermann et al., 2013; Ma and Teasdale, 2004; Omid et al., 2013; Teasdale et al., 2000; Williams et al., 2014). Nine studies were at high risk for attrition bias (Britton et al., 2010; Chiesa, Mandelli and Serretti, 2012; Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Keune et al., 2011b; Kuyken et al., 2008; Manicavasgar, Parker and Perich, 2011; Segal et al., 2010; Shahar et al., 2010). One study was unclear (van Aalderen et al., 2012).

Selective outcome reporting. Six studies had low risk of reporting bias because we were able to identify an a priori trial registration entry (Godfrin and van Heeringen, 2010; Keune et al., 2011a; Kuyken et al., 2008; Segal et al., 2010; van Aalderen et al., 2012; Williams et al., 2014). Ten studies had unclear risk of reporting bias because we were unable to identify such an entry (Barnhofer et al., 2009; Bondolfi et al., 2010; Britton et al., 2010; Chiesa, Mandelli and Serretti, 2012; Forkmann et al., 2014; Geschwind et al., 2012; Hepburn, Crane, Barnhofer et al., 2009; Jermann et al., 2013; Ma and Teasdale, 2004; Manicavasgar, Parker and Perich, 2011; Omid et al., 2013; Shahar et al., 2010; van Aalderen et al., 2012). One study was high risk because we identified a trial registration entry and the study did not report on all identified outcomes (Teasdale et al., 2000).

Other. Two studies did not provide an adequate description of the study to be able to determine whether other risk to biases existed (Godfrin and van Heeringen, 2010; Omid et al., 2013). Five studies were low risk for other biases because no other issues were identified (Bondolfi et al., 2010; Chiesa, Mandelli and Serretti, 2012; Kuyken et al., 2008; Ma and Teasdale, 2004; Teasdale et al., 2000). The remainder of the studies suffered from one or more potential biases (Barnhofer et al., 2009; Britton et al., 2010; Geschwind et al., 2012; Hepburn, Crane, Barnhofer et al., 2009; Keune et al., 2011a; Manicavasgar, Parker and Perich, 2011; Segal et al., 2010; Shahar et al., 2010; van Aalderen et al., 2012; Williams et al., 2014).

Table 3.2: Risk of Bias for Each MBCT Randomized Controlled Trial

Study ID	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants (performance bias)	Blinding of outcome assessors (detection bias)	Completeness of reporting outcome data (attrition bias)	Selective outcome reporting (reporting bias)	Other biases (balance of confounders, cross-overs/contamination, measurement, intervention definition, ITT)	USPSTF Quality rating (Good, Fair, Poor)(US Preventive Services Task Force)
Barnhofer et al., 2009	Low risk	Low risk	High risk	Low risk	Low risk	Unclear	Differences in chronic depression among completers at baseline	Good
Batink et al. 2013 Geschwind et al., 2012; Forkmann et al., 2014	Low risk	Low risk	High risk	Low risk	Low risk	unclear	Differences in employment and comorbid anxiety disorder; marginal differences in gender and use of antidepressants at baseline	Fair
Bondolfi et al., 2010; Jermann et al., 2013	Low risk	Low risk	High risk	Low risk	Low risk	Unclear	None	Good
Britton et al., 2010	Low risk	Low risk	High risk	Low risk	High risk	Unclear	Differential dropout between arms; no ITT	Poor
Chiesa et al. 2012	Low risk	Unclear	Unclear	Low risk	High risk		None	Fair
Godfrin and van Heeringen, 2010	Low risk	Low risk	High risk	Low risk	High risk	Low risk	Unclear	Fair

Hepburn et al., 2009; Crane et al., 2008	Unclear	Unclear	High risk	Low risk	High risk	Unclear	No ITT; Non-completers were significantly younger than completers	Poor
Keune et al., 2011 Bostanov et al., 2012	Low risk	Low risk	High risk	Low risk	High risk	Low risk	No ITT	Poor
Kuyken et al., 2008 Kuyken et al., 2010	Low risk	Unclear	High risk	Low risk	High risk	Low risk	None	Fair
Ma and Teasdale, 2004	Low risk	Low risk	High risk	Low risk	Low risk	Unclear	None	Good
Manicavasgar, Parker and Perich, 2011	High risk	Low risk	High risk	Unclear	High risk	Unclear	No ITT	Poor
Omidi et al., 2013	Unclear	Unclear	Unclear	Unclear	Low risk	Unclear	Substantive differences between arms at baseline Unclear	Poor
Segal et al., 2010	Low risk	Low risk	High risk	Low risk	High risk	Low risk	Differences in any axis 2 comorbidity at baseline	Fair
Shahar et al., 2010	Low risk	Low risk	High risk	Low risk	High risk	Unclear	No ITT	Poor
Teasdale et al., 2000 Teasdale et al., 2002 Williams et al., 2000	Low risk	Low risk	High risk	Low risk	Low risk	High risk	None	Good
Van Aalderen et al., 2012	Low risk	Unclear	High risk	unclear	Unclear	Low risk	No ITT; differential dropout	Poor
Williams et al., 2014	Low risk	Low risk	High risk	Low risk	Low risk	Low risk	No ITT; Non-completers were significantly younger than completers	Poor

Key Question 1: Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with MDD?

We did not identify any study in patients with a current diagnosis of MDD that reported on the effectiveness of MBCT given as monotherapy.

We identified one study in patients in full or partial remission that explicitly assessed MBCT as monotherapy and reported on depressive symptoms. The RCT with 26 enrolled participants (Britton et al., 2010) was rated poor quality due to not performing ITT analyses and having unequal dropout in the study arms. The intervention consisted of eight weekly sessions and a one-day retreat. Study participants had a history of at least three depressive episodes. The study reported significantly greater reductions in depressive symptom scores in the MBCT arm compared to waitlist (SMD -1.11; 95% CI -2.07, -0.15; 1 RCT).

Three studies (Keune et al., 2011b; Manicavasgar, Parker and Perich, 2011; Shahar et al., 2010) were identified that did not indicate systematic co-interventions, such as antidepressants or TAU as recommended by their primary healthcare provider. Combined with the explicit monotherapy study, the pooled effect indicated MBCT is potentially associated reductions in depressive symptom scores versus other comparators including waitlist or CBT without mindfulness meditation (SMD -1.07, 95% CI -2.21, 0.08; I^2 80%; 4 RCTs). A meta-regression indicated no statistically significant differences in the results between the monotherapy ($p=0.49$) and unclear ($p=0.26$) studies compared to adjunctive MBCT studies. Results from another meta-regression showed unclear studies were possibly different from monotherapy studies ($p=0.06$). Thus, the unclear studies were included in the analyses with adjunctive MBCT studies.

Key Question 1a: Among publications that address monotherapy meditation as a treatment for adults with MDD, how common and severe are adverse events?

Only two studies explicitly assessed MBCT as monotherapy (one reporting on depressive symptoms, one on relapse). One of the two reported that no adverse events occurred during the trial (Britton et al., 2010), but did not report whether there was systematic monitoring for adverse events or which events were assessed.

Key Question 1b. Does the efficacy differ depending on the characteristics of monotherapy meditation used?

The only identified explicit monotherapy study followed the standard MBCT program. The study reported on meditation practice and reported no correlation between depression scale scores and mindfulness meditation practice outside of class (Britton et al., 2010).

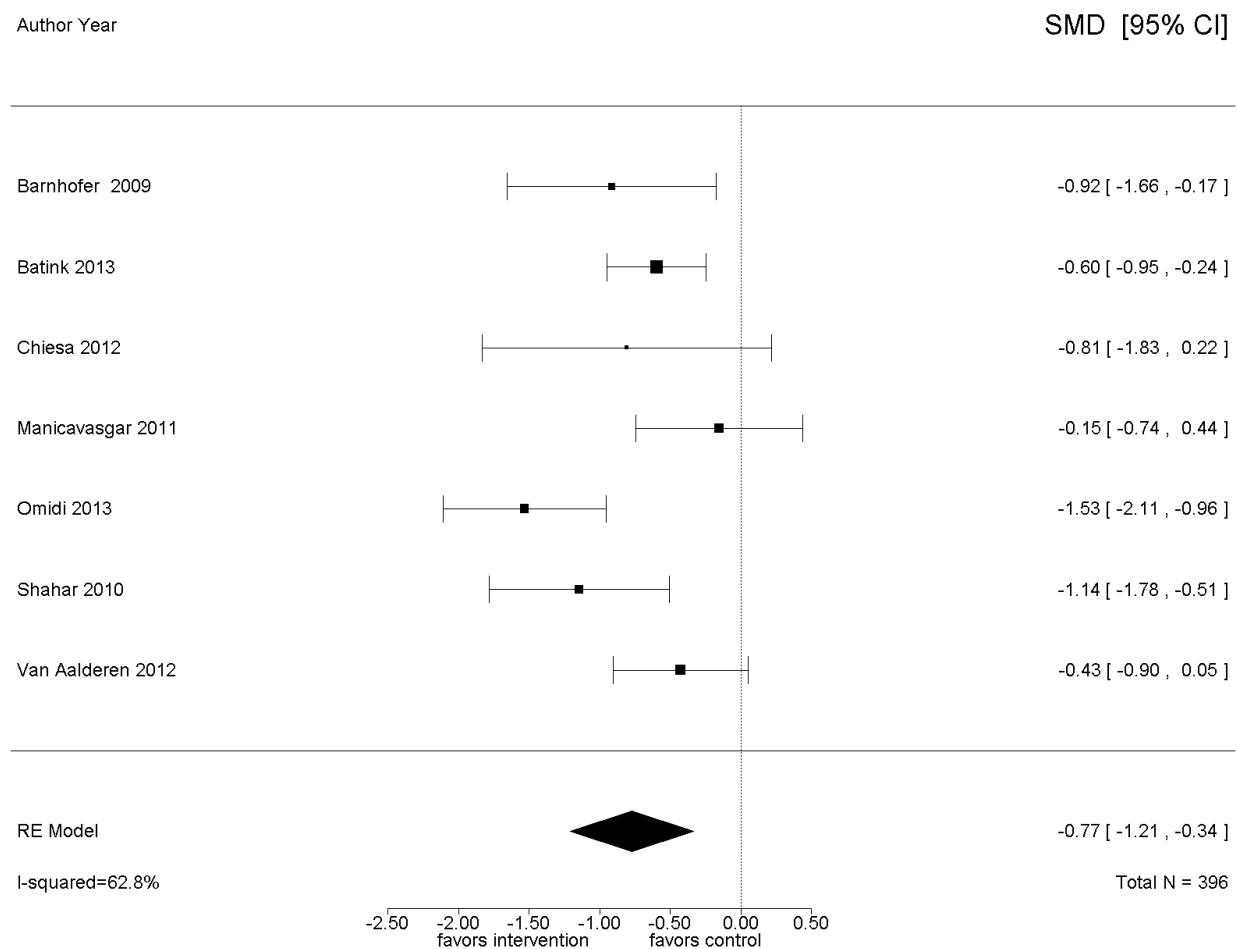
Key Question 2: Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with MDD?

Participants in seven studies had a clinical diagnosis of MDD, were experiencing a depressive episode, or had residual symptoms when they enrolled in the study, which we refer to as active depression (Barnhofer et al., 2009; Batink et al., 2013; Chiesa, Mandelli and Serretti, 2012; Manicavasgar, Parker and Perich, 2011; Omidi et al., 2013; Shahar et al., 2010; van Aalderen et al., 2012). Studies compared MBCT to waitlist, TAU alone, psycho-education, or CBT without mindfulness meditation. The pooled analysis across these studies showed significantly greater improvement for MBCT than comparators (SMD -0.77, 95% CI -1.21, -0.34; I^2 63%; 7 RCTs). There was substantial heterogeneity in study results (see Figure 3.2).

The effect estimate was similar when excluding two studies (Manicavasgar et al., 2011; Shahar et al., 2010) that did not report a systematic co-intervention or explicitly referred to ongoing TAU (SMD -0.83, 95% CI -1.38, -0.27; I^2 61%; 5 RCTs).

One of the studies with participants who had a clinical diagnosis of MDD, were experiencing a depressive episode, or had residual symptoms when they enrolled in the study also examined response to treatment (i.e., at least a 50 percent reduction in depressive symptom score on a standardized scale) (Barnhofer et al., 2009). Participants were assigned to either MBCT and TAU or TAU alone. The response rate was not statistically significantly different between the MBCT group and TAU alone (RR 0.18, 95% CI 0.02, 1.31).

Figure 3.2: Efficacy of adjunctive MBCT of depressive symptoms – active depression

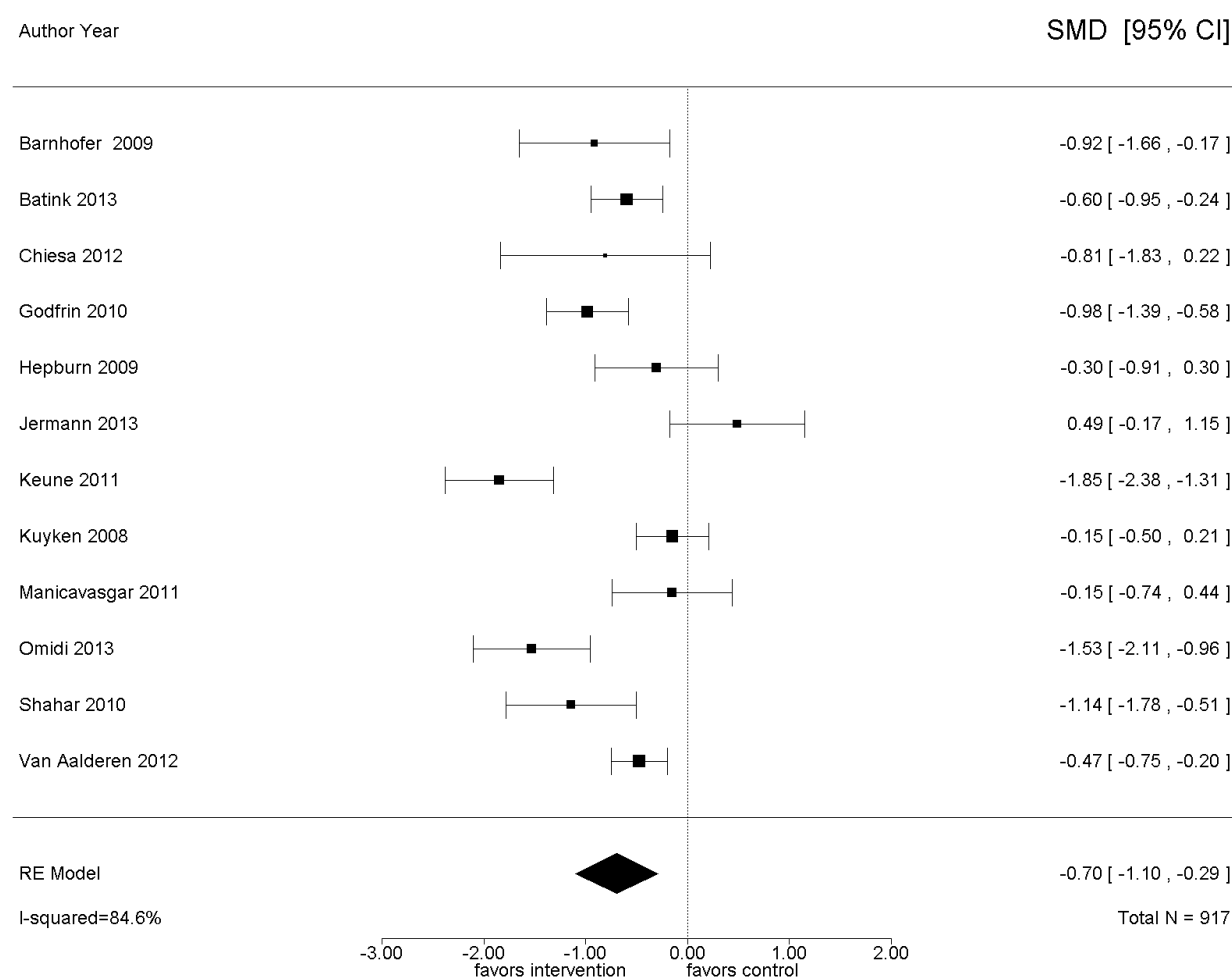


We identified 12 RCTs in total that examined the effect of adjunctive MBCT on depressive symptoms scores (Barnhofer et al., 2009; Batink et al., 2013; Chiesa, Mandelli and Serretti, 2012; Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Jermann et al., 2013; Keune et al., 2011a; Kuyken et al., 2008; Manicavasgar, Parker and Perich, 2011; Omidi et al., 2013; Shahar et al., 2010; van Aalderen et al., 2012). Studies included patients with current MDD or patients with a history of MDD but currently in remission. The primary treatment was TAU in seven studies (Barnhofer et al., 2009; Batink et al., 2013; Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Manicavasgar, Parker and Perich, 2011; Omidi et al., 2013; van Aalderen et al., 2012), TAU without antidepressants in one study (Bondolfi et al., 2010), and antidepressants in four studies (Chiesa, Mandelli and Serretti, 2012; Keune et al., 2011a; Kuyken et al., 2008; Shahar et al., 2010). The most common comparator was TAU (seven studies) (Barnhofer et al., 2009; Batink et al., 2013; Bondolfi et al., 2010; Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Omidi et al., 2013; van Aalderen et al., 2012). The comparator for three studies was antidepressants either alone (Kuyken et al., 2008);

with waitlist (Keune et al., 2011a), or with psycho-education (Chiesa, Mandelli and Serretti, 2012). Two studies included CBT comparators (Manicavasgar, Parker and Perich, 2011; Omid et al., 2013).

The pooled analysis across the twelve studies indicated statistically significant greater improvement in the MBCT group than for the comparator interventions (SMD -0.72, 95% CI -1.14, -0.30; I^2 85%; 12 RCTs) (see Figure 3.3). However, there was substantial heterogeneity. We found no evidence of publication bias for relapse (Egger's test: $p = 0.80$, Begg's test: $p = 1.00$).

Figure 3.3: Efficacy of adjunctive MBCT on depressive symptoms in MDD and prior MDD



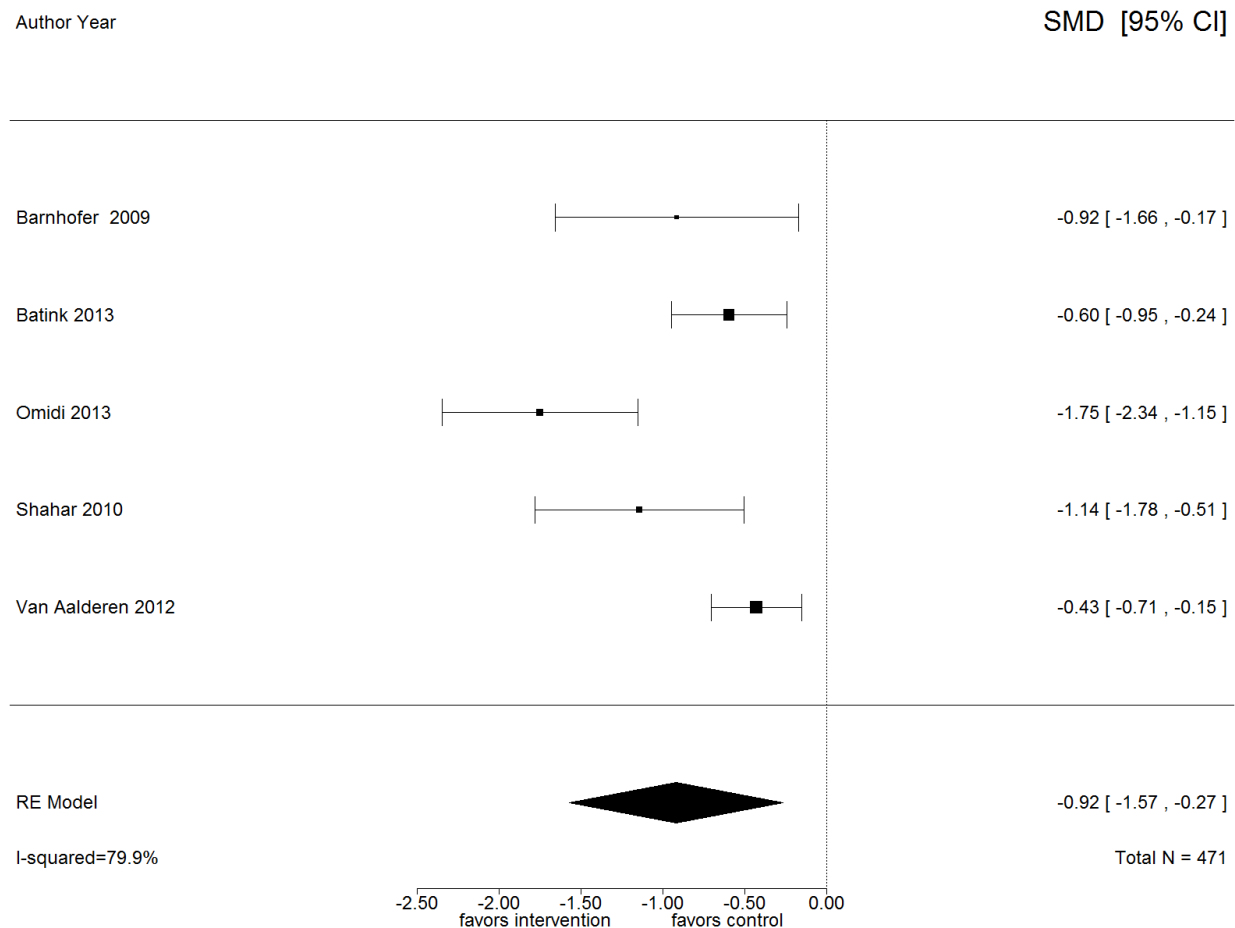
Of note, the effect of adjunctive MBCT was less consistent among the five studies focused on those with a history of MDD who were not currently experiencing residual depressive symptoms. The primary treatment was TAU in three studies (Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Jermann et al., 2013) and antidepressants in two studies

(Keune et al., 2011a; Kuyken et al., 2008). The most common comparator was TAU (three studies) (Godfrin and van Heeringen, 2010; Hepburn, Crane, Barnhofer et al., 2009; Jermann et al., 2013). The comparator for two studies was antidepressants either alone (Kuyken et al., 2008) or with waitlist (Keune et al., 2011a). Pooled across all studies there was no statistically significant differences between MBCT and comparator interventions among studies whose participants had a history of depression, but were not currently depressed (SMD -0.57, 95% CI -1.67, 0.53; I^2 92%; 5 RCTs) and there was substantial heterogeneity across studies.

MBCT plus TAU versus TAU

Five studies of mixed quality with 471 enrolled participants with current MDD or residual depressive symptoms reported a comparison of MBCT plus TAU and TAU alone. All studies showed significantly greater improvement among those receiving MBCT (Barnhofer et al., 2009; Batink et al., 2013; Omid et al., 2013; Shahar et al., 2010; van Aalderen et al., 2012). The pooled effect showed MBCT plus TAU to be statistically significantly superior to TAU alone in reducing depressive symptoms (SMD -0.92; 95% CI -1.57, -0.27; I^2 80%; 5 RCTs). However, there was substantial heterogeneity across studies, see Figure 3.4.

Figure 3.4: Adjunctive MBCT versus TAU on depressive symptoms



MBCT plus antidepressants versus antidepressants alone

One fair quality study with 123 enrolled participants compared adjunctive MBCT used with tapered maintenance antidepressants to antidepressants alone (Kuyken et al., 2008) in a sample of individuals who had experienced three or more previous depressive episodes. The tapering of antidepressants started in week four to five of the eight week MBCT intervention. There were no statistically significant differences in the change in residual depressive symptoms between the MBCT group plus antidepressant and the antidepressant alone group a month after the intervention using the HRSD (SMD -0.30; 95% CI -0.66, 0.05), and marginal difference using the BDI (SMD -0.36; 95% CI -0.72, 0.00) in intention-to-treat analyses. Nor were there statistically significant differences at 15-months after baseline in either the HRSD (SMD -0.23; 95% CI -0.58, 0.13) or BDI (SMD -0.33; 95% CI -0.69, 0.03).

MBCT plus TAU versus CBT plus TAU

Two poor quality studies with 159 enrolled participants compared adjunctive MBCT to adjunctive CBT (Manicavasgar, Parker and Perich, 2011; Omid et al., 2013). Among currently depressed patients, both MBCT and CBT were associated with significant improvements in depressive symptoms over the 8-week study period with no differences in improvement between the two groups in one study (Manicavasgar, Parker and Perich, 2011); there were also no statistically significant differences between MBCT and CBT at the 6-month and 12-month follow-ups. In a sample of currently depressed individuals that were randomized to MBCT, TAU or CBT, Omid and colleagues (2013) also reported no statistically significant difference in improvement in depressive symptom scores between the MBCT and CBT groups (Omid et al., 2013). The pooled result was SMD -0.06 (95% CI -1.01, 0.89; 2 RCTs I^2 0%) indicating that mindfulness meditation did not statistically significantly improve depression scores compared to traditional CBT.

MBCT plus antidepressants versus psycho-education plus antidepressants

A single fair quality study with 18 enrolled participants with major depression who did not achieve remission following at least eight weeks of antidepressant treatment compared MBCT to a psycho-education intervention that focused on the criteria for MDD and underlying cognitive dysfunctions, and pharmacologic and psychological treatments for MDD (Chiesa, Mandelli and Serretti, 2012). There was no statistically significant difference in HRSD scores at the end of the intervention compared to the psycho-education intervention (SMD -0.81; 95% CI -1.83, 0.22).

Key Question 2a: Among publications that address adjunctive meditation as a treatment for adults with MDD, how common and severe are adverse events?

Five MBCT RCTs of mixed quality addressed adverse events (Barnhofer et al., 2009; Geschwind et al., 2012; Kuyken et al., 2008; Shahar et al., 2010; Williams et al., 2014). Three studies reported that no adverse events occurred (Geschwind et al., 2012; Kuyken et al., 2008; Shahar et al., 2010). One study reported that none of the adverse events were deemed to be related to the treatment but one participant in the MBCT group contacted the therapist during a suicidal crisis and after crisis intervention was referred to their psychiatrist (Barnhofer et al., 2009). One MBCT study (Williams et al., 2014) reported that 15 serious adverse events occurred, only one of which was thought to be related to the study interventions (the event occurred in the cognitive psychological education [CPE] arm). None of the studies stated whether the occurrence of adverse events was systematically assessed.

Key Question 2b. Does the efficacy differ depending on the type of adjunctive meditation used?

There was insufficient evidence to answer this question. A meta-regression analyzing differences between studies following the original MBCT manual versus studies that used a modified MBCT intervention indicated deviations were not significantly associated with MBCT results ($p=0.70$).

One study of patients with a history of at least three previous depressive episodes, some of whom were experiencing depression at the time of the study, found a weak correlation between the amount formal meditation practiced outside the class and change in depressive symptom score during MBCT ($r=0.26$, $p<.05$).

Key Question 3: Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with MDD?

One fair quality study with 84 participants compared the effect on relapse rates at 18 months following treatment of MBCT to two control groups: 1) antidepressants and 2) antidepressant placebo plus clinical management in a sample in remission with a history of at least three previous episodes of depression (Segal et al., 2010). The intervention consisted of eight weekly sessions as well as an all-day retreat. In addition, participants had daily homework exercises. Overall, there were no statistically significant differences in relapse rates between either MBCT and antidepressants (RR 0.80; 95% CI 0.39, 1.62) or between monotherapy MBCT and antidepressant placebo plus clinical management (RR 0.65; 95% CI 0.34, 1.62). Among those in stable remission, there were no statistically significant differences in relapse rates between either MBCT and antidepressants (RR 1.25; 95% CI 0.60, 2.59), or between monotherapy MBCT and antidepressant placebo plus clinical management (RR 1.06; 95% CI 0.54, 2.07). Among those in unstable remission, MBCT was associated with statistically significantly lower relapse rate compared to antidepressant placebo plus clinical management (RR 0.39; 95% CI 0.17, 0.88), but not compared to antidepressants (RR 1.02; 95% CI 0.30, 3.45). There were not enough studies to test for publication bias.

Key Question 3a. Does the efficacy differ depending on the type of monotherapy meditation used?

The monotherapy study that reported on depression relapse followed the standard MBCT protocol and did not report on associations between meditation characteristics (e.g., frequency

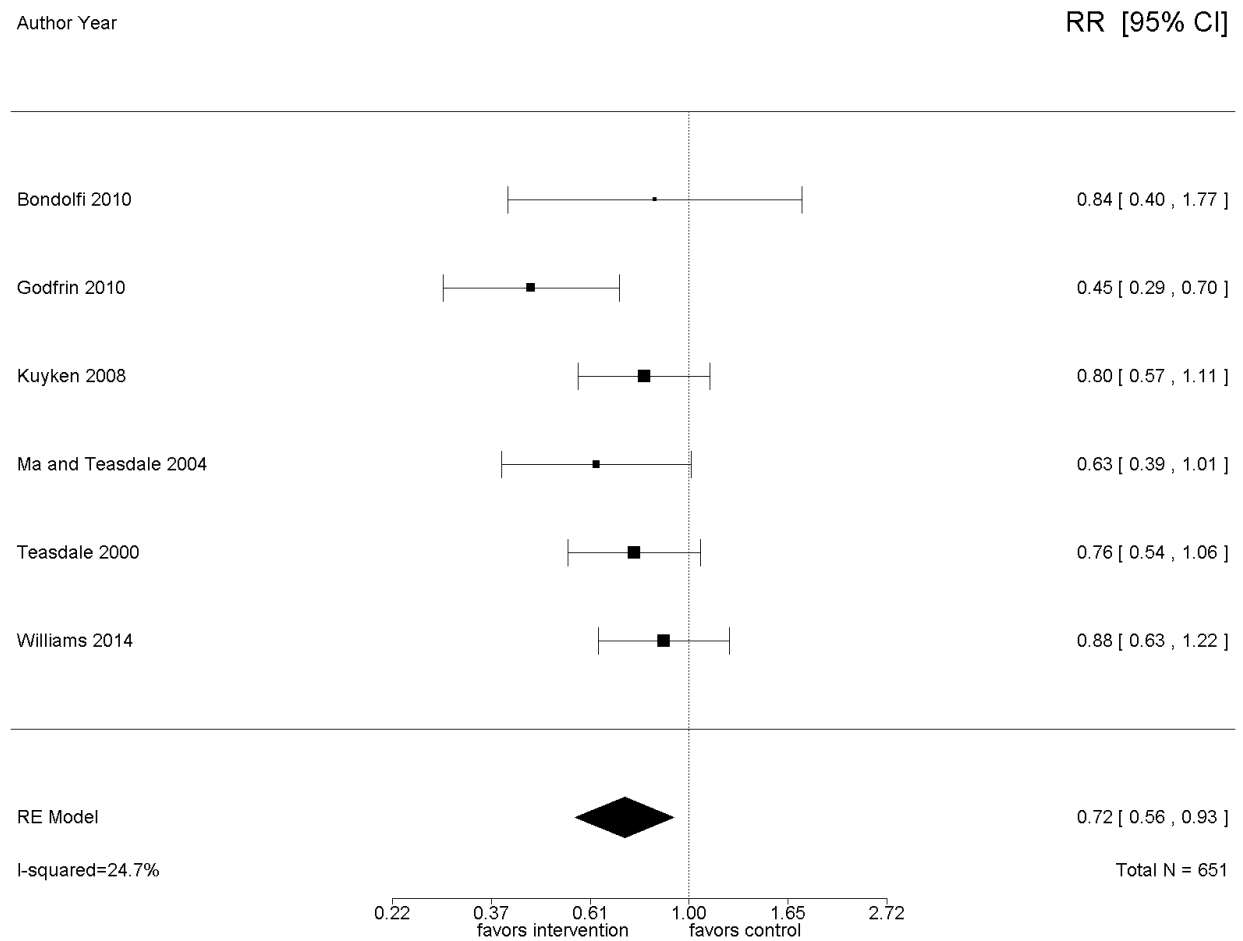
outside of class) and the occurrence of relapse. Hence there is insufficient evidence to address this question.

Key Question 4: Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with MDD?

We did not identify any study that randomized patients with MDD to an MBCT intervention and reported on long-term follow-up to assess later relapse after initial treatment response.

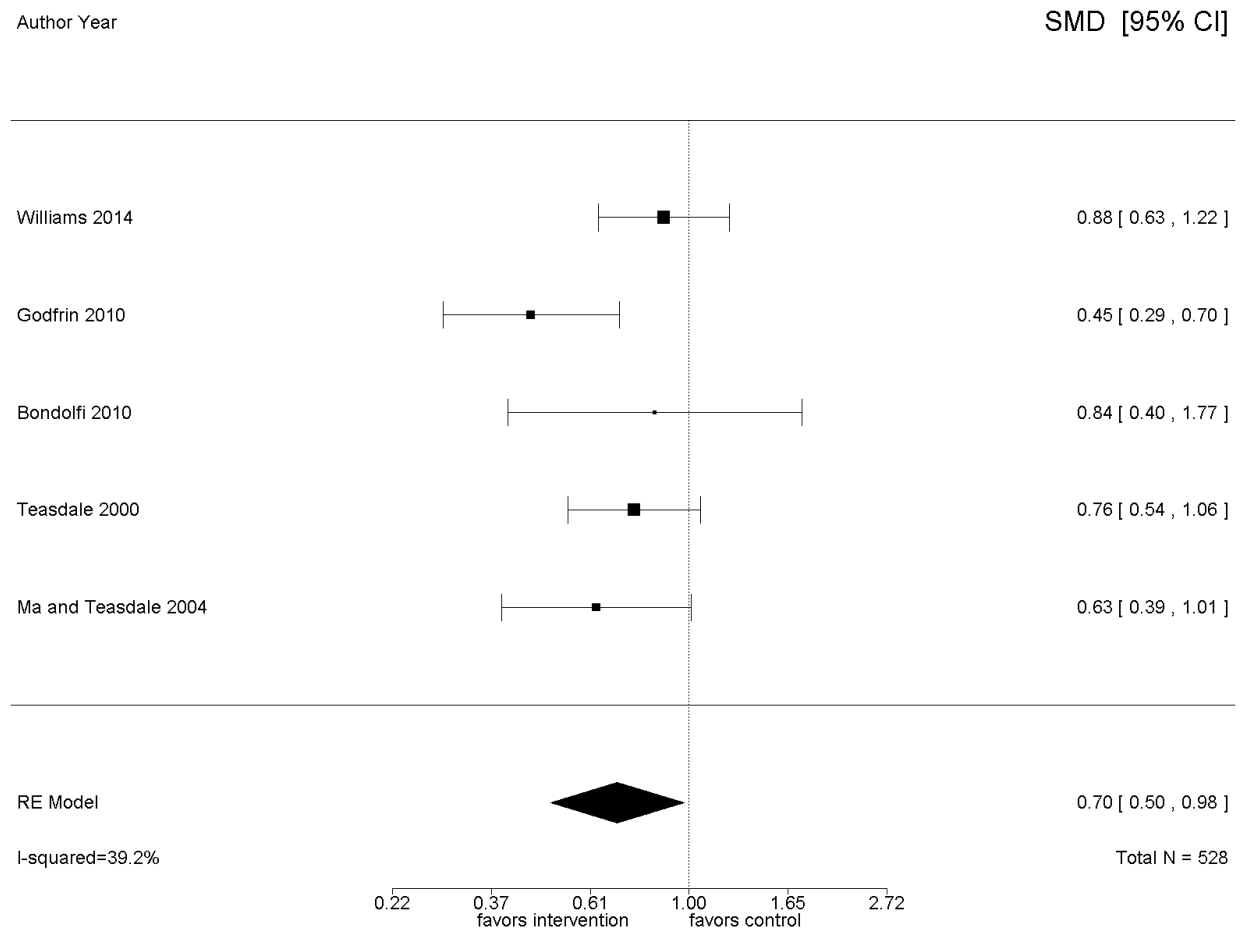
We identified six RCTs that addressed MBCT as an adjunct treatment for patients with a history of MDD that included an assessment of relapse (Bondolfi et al., 2010; Godfrin and van Heeringen, 2010; Kuyken et al., 2008; Ma and Teasdale, 2004; Teasdale et al., 2000; Williams et al., 2014). The studies enrolled 651 participants with a history of multiple previous depressive episodes. These studies were mostly good or fair quality. Two of the studies required at least two previous depressive episodes (Ma and Teasdale, 2004; Teasdale et al., 2000) while four required at least three previous depressive episodes (Bondolfi et al., 2010; Godfrin and van Heeringen, 2010; Kuyken et al., 2008; Williams et al., 2014) to be included in the trial. Four of the studies provided MBCT adjunctive to TAU and the comparator was TAU. In the fifth study, MBCT was adjunctive to TAU and compared to two groups: TAU alone or CPE. The sixth study was adjunctive to and compared to maintenance antidepressants (Kuyken et al., 2008). The pooled estimate showed a statistically significant reduction of relapse rate for MBCT compared to control (RR 0.72; 95% CI 0.56, 0.93; I^2 25%; 6 RCTs) (see Figure 3.5). We found no evidence of publication bias for relapse (Egger's test: $p = 0.55$, Begg's test: $p = 0.27$).

Figure 3.5: Adjunctive MBCT and relapse



The pooled estimate for the five studies that compared MBCT with TAU to TAU showed a statistically significant reduction of relapse rate for MBCT (RR 0.70; 95% CI 0.50, 0.98; I^2 39%; 5 RCTs) (see Figure 3.6).

Figure 3.6: Adjunctive MBCT versus TAU on relapse



Several studies indicated that treatment effects were stronger in among patients with at least three prior episodes of depression in at least partial recovery. In one study, significantly fewer patients receiving MBCT with TAU showed relapse compared to patients receiving TAU only (RR 0.45; 95% CI 0.29, 0.70), and the mean time to first relapse was longer (39.5 weeks versus 53.7; $p < 0.001$) (Godfrin and van Heeringen, 2010). Similarly, another study demonstrated a reduction in the risk of relapse among participants MBCT with TAU compared to TAU only (RR 0.61; 95% CI 0.41, 0.89) (Teasdale et al., 2000). Two studies found no statistically significant differences in relapse rates between recurrently depressed patients receiving MBCT plus TAU versus either TAU only (RR 0.88; 95% CI 0.63, 1.22) (Williams 2014), maintenance medication (RR 0.80; 95% CI 0.57, 1.11) (Kuyken et al., 2008), or CPE (RR 0.93, 95% CI 0.70, 1.24) (Williams et al., 2014). One study showed no statistically significant differences in relapse rates between patients receiving MBCT and TAU compared to TAU only (RR 0.84; 95% CI 0.40, 1.77), but did find a significant reduction in the time to relapse in the intervention group compared to TAU only (204 days versus 68 days; $p = 0.006$) (Bondolfi et al., 2010). The pooled

estimate for subgroups of participants with at least three or more previous depressive episodes had a RR of 0.66 (95% CI 0.48, 0.90; I^2 47%; 6 RCTs). In contrast, two studies found that adjunctive MBCT did not reduce risk of relapse among patients with two prior episodes of depression: (RR 2.50; 95% CI 0.60, 10.34) (Ma and Teasdale, 2004) and (RR 1.80; 95% CI 0.77, 4.19) (Teasdale et al., 2000). The pooled estimate for the subgroup of participants with two previous episodes had a RR of 1.96 (95% CI 0.31, 12.29; I^2 0%; 2 RCTs). A meta-regression indicated that the number of depressive episodes is potentially associated with the treatment success but the results were not statistically significant ($p=0.07$).

Key Question 4a. Does the efficacy differ depending on the type of adjunctive meditation used?

There was insufficient evidence to answer this question. A meta-regression analyzing differences between studies following the original MBCT manual versus studies that used a modified MBCT intervention indicated that deviations were not significantly associated with relapse ($p=0.33$).

Two studies reported an analysis of the effect of meditation characteristics on relapse rates. One study examined the relationship between maintenance of regular practice during the intervention, the six months following the intervention, six to twelve months after the intervention by patients who had experienced at least three previous depressive episodes but were in remission at the time of the study and relapse. The amount of sitting meditation, three-minute breathing space and informal space did not differ during any time period for those who did and did not relapse. Individuals who relapsed were engaged in significantly more body scan practice six to twelve months after completing MBCT (Bondolfi et al., 2010).

One study explored whether depression relapse among patients with recurrent depression was associated with the MBCT instructor, a clinical psychologist and an occupational therapist. Both instructors had participated in a training program and run pilot MBCT groups with supervision. An independent MBCT therapist reviewed videotapes of the MBCT sessions and confirmed the competency of both instructors. There was no significant difference in relapse rates across the therapists or the groups they led (Kuyken et al., 2008).

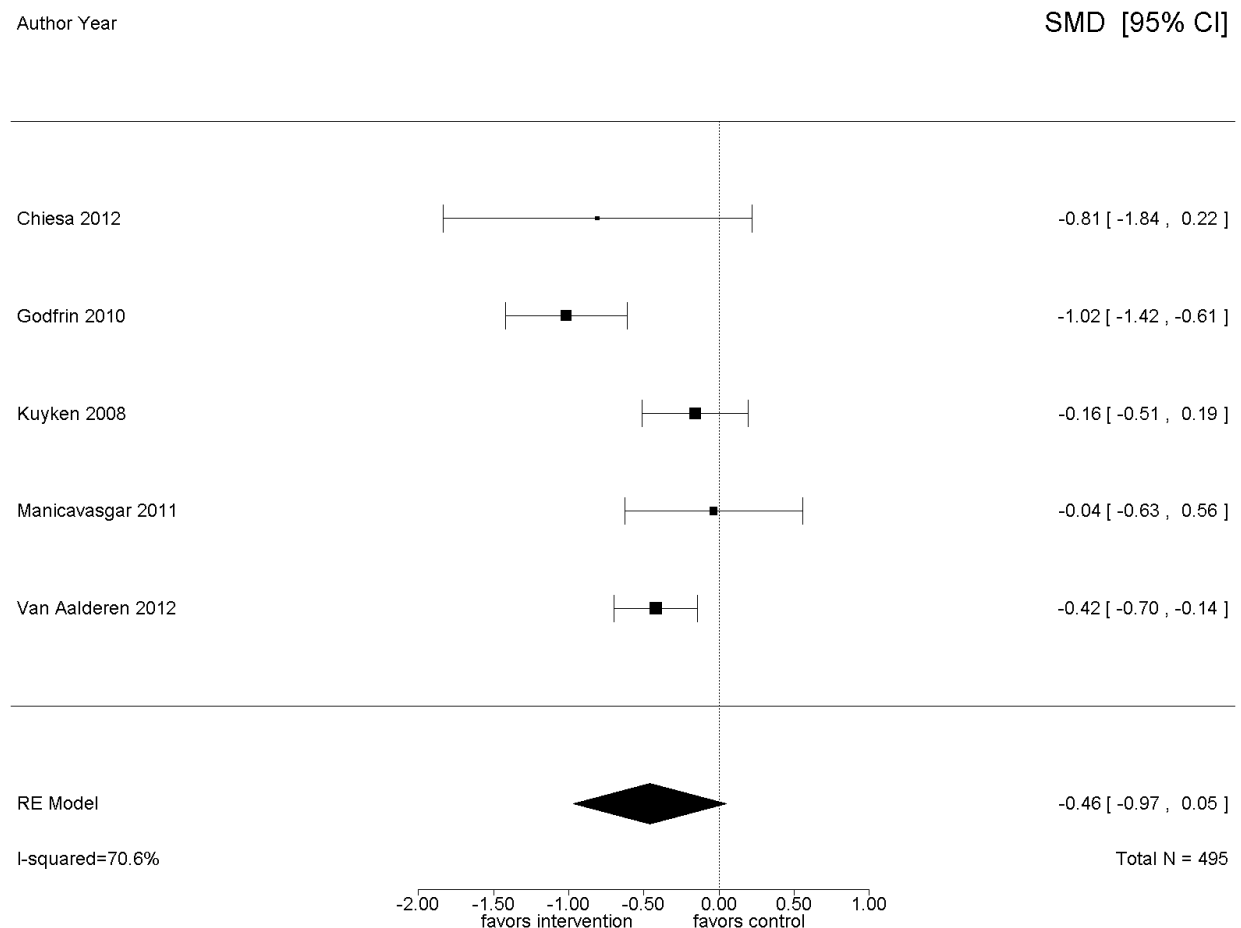
Key Question 5: Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving health-related quality (HR-QOL) of life in adults with MDD?

We did not identify any study that assessed whether monotherapy MBCT was associated with improved health-related quality of life among adults with MDD.

Key Question 6: Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving HR-QOL in adults with MDD?

Five studies assessed whether adjunctive MBCT was associated with improved health-related quality of life among adults with MDD; three of the studies included individuals experiencing a depressive episode or residual depressive symptoms (Chiesa, Mandelli and Serretti, 2012; Manicavasgar, Parker and Perich, 2011; van Aalderen et al., 2012), while two focused on individuals with a history of depression who were not experiencing residual symptoms (Godfrin and van Heeringen, 2010; Kuyken et al., 2008). The pooled estimate showed no significant differences in quality of life in the MBCT groups compared to control (SMD -0.42; 95% CI -0.70, -0.14; I^2 71%; 5 RCTs) (see Figure 3.7).

Figure 3.7: Adjunctive MBCT and Health-Related Quality of Life



MBCT plus TAU versus TAU alone

Two studies (one fair and one poor quality) with 325 enrolled participants compared MBCT to TAU on quality of life measures. In a study comparing MBCT to TAU among recurrently depressed (defined as at least three prior episodes) patients, MBCT was associated with better scores on the WHO Quality of Life psychological subscale compared to TAU (SMD -0.38, 95% CI -0.66, -0.11), but not the physical (SMD -0.42, 95% CI -0.70, -0.14) or social subscales (SMD= -0.09, 95% CI -0.36, 0.18). In a subgroup of patients who were currently depressed (n=69), scores also favored MBCT compared to TAU on the psychological subscale (SMD -0.49, 95% CI -0.77, -0.21), but not the physical (SMD -0.17, 95% CI -0.44, 0.11) or social (SMD 0.26, 95% CI -0.53, 0.02) subscales (van Aalderen et al., 2012). In a second study among currently remitted patients with at least three prior depressive episodes, MBCT was associated with better HR-QOL as measured by the Quality of Life in Depression Scale compared to TAU at 8-weeks (SMD -1.02, 95% CI -1.42, -0.61), 8-months (SMD -0.67, 95% CI -1.06, -0.28) and 14-months (SMD -0.68, 95% CI -1.07, -0.29) after baseline (Godfrin and van Heeringen, 2010).

MBCT plus maintenance antidepressants versus maintenance antidepressants alone

One fair quality study of MBCT versus maintenance antidepressants with 123 enrolled participants compared HR-QOL for currently remitted patients with at least three prior depressive episodes, MBCT compared to maintenance antidepressants (Kuyken et al., 2008). There were not significant differences in QOL at one-month post-treatment between MBCT and maintenance antidepressants in the physical (SMD -0.10, 95% CI -0.46, 0.25), psychological (SMD -0.16, 95% CI -0.51, 0.19) or social (SMD -0.21, 95% CI -0.56, 0.15) domains of the WHO-QOL (Kuyken et al., 2008).

MBCT plus antidepressants versus psycho-education plus antidepressants

In a fair quality study of 18 patients with major depression and who did not achieve remission following at least eight weeks of antidepressant treatment, there was not a significant difference in HR-QOL measured by the Psychological General Well-Being Index in the MBCT group compared to a psycho-education control group (SMD -0.81, 95% CI -1.84, -0.22) (Chiesa, Mandelli and Serretti, 2012).

MBCT plus antidepressants versus CBT plus antidepressants

One poor quality study with 69 currently depressed patients compared changes in HR-QOL as measured by the Social and Occupational Functioning Scale (SOFAS) in a group receiving MBCT to those receiving CBT (Manicavasgar, Parker and Perich, 2011). There was no significant difference in HR-QOL between groups (SMD 0.04, 95% CI -0.63, 0.56).

Key Question 7: Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with MDD?

None of the monotherapy studies examined the effect of interventions on the use of antidepressants.

Key Question 8: Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with MDD?

Six studies of good and fair quality were identified that examined the impact of adjunctive MBCT on antidepressant use. Five studies found no significant differences in reductions, changes, or reinstatement of antidepressants use over time or between groups (Barnhofer et al., 2009; Bondolfi et al., 2010; Godfrin and van Heeringen, 2010; Ma and Teasdale, 2004; Teasdale

et al., 2000), while one study found the cost of antidepressant was significantly lower in the MBCT group (Kuyken et al., 2008). In one study among patients with a history of recurrent depression and a history of treatment by a recognized antidepressant, but currently off antidepressant medication, and in at least partial remission, there were no significant differences in the proportion of patients using antidepressants at any time over the 52-week follow-up period between the MBCT and TAU group compared to the TAU only group (40 vs 45 percent, $p=0.10$) (Teasdale et al., 2000). In a similar patient sample, another study found no difference between adjunctive MBCT and TAU in the use or dosage of antidepressants over a 60 week study period (Ma and Teasdale, 2004). Another study of adjunctive MBCT among patients with a history of at least three prior depressive episodes currently in at least partial remission (as defined by the study) (Godfrin and van Heeringen, 2010) similarly found no significant differences in antidepressant medication use over a 14-month follow-up period between patients receiving MBCT plus TAU (baseline: 73 percent versus 14-month follow-up: 64 percent) compared to TAU only (baseline: 61 percent versus 14-month follow-up: 62 percent). A study of individuals in remission with a history of recurrent major depression with at least two episodes in the last five years found no difference in antidepressant reinstatement during the study between MBCT plus TAU (36 percent) and TAU (31 percent). The pooled estimate showed no significant differences in antidepressant use in the MBCT groups compared to control (RR -0.01; 95% CI -0.34, 0.32; I^2 18%; 4 RCTs). A fifth study of patients with current MDD or residual symptoms following an MDD episode found differences that approached statistical significance in the percentage of participants with changes in their antidepressant use during the study period (14 percent in MBCT plus TAU versus 50 percent in TAU group, $p=0.052$) (Barnhofer et al., 2009).

The sixth study included participants with a history of three or more episodes of depression on maintenance antidepressants. Over a 15 month follow-up period, this study found the cost of antidepressants was \$103 less (95% CI -\$191 to -\$14) in the MBCT group than maintenance antidepressant group over a fifteen month period (Kuyken et al., 2008).

4. Discussion

Summary of Findings

The evidence on the efficacy of MBCT for MDD has expanded in recent years. We identified 17 relevant studies investigating MBCT for the prevention of MBCT relapse as well as the reduction of depression symptoms. Data on quality of life remains sparse and adverse events have not been systematically assessed.

Key Question 1. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with MDD?

We did not identify any study in patients with a current diagnosis of MDD that reported on the effectiveness of MBCT given as monotherapy. We identified one study in patients in full or partial remission that explicitly assessed MBCT as monotherapy and reported on depressive symptoms. There was very low quality evidence that MBCT reduces depressive symptoms more than waitlist control (SMD -1.11; 95% CI -2.07, -0.15; 1 RCT).

Key Question 1a. Among publications that address monotherapy meditation as a treatment for adults with MDD, how common and severe are adverse events?

Only two studies explicitly assessed MBCT as monotherapy (one reporting on depressive symptoms, one on relapse). One of the two addressed adverse events and reported that no adverse events occurred during the trial (Britton et al., 2010), but did not report whether there was systematic monitoring for adverse events.

Key Question 1b. Does the efficacy differ depending on the characteristics of meditation used?

The only identified monotherapy study followed the standard MBCT program. The study reported on meditation practice and reported no correlation between depression scale scores and mindfulness meditation practice outside of class.

Key Question 2. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing depressive symptoms in adults with MDD?

There was moderate quality evidence of MBCT reducing depressive symptoms in patients with MDD compared to all comparators (SMD -0.77, 95% CI -1.21, -0.34; I^2 63%; 7 RCTs).

Twelve RCTs examined adjunctive MBCT on depressive symptom scores. There was moderate evidence in support of the use of adjunctive MBCT overall interventions (SMD -0.72, 95% CI -1.14, -0.30; I^2 85%; 12 RCTs). There was moderate evidence of its efficacy compared to TAU (SMD -0.92, 95% CI -1.57, -0.27; I^2 80%; 5 RCTs). The evidence suggested that MBCT had no significant effect on residual depressive symptom scores among those with a history of depression, but not currently depressed (SMD -0.57, 95% CI -1.67, 0.53; I^2 92%; 5 RCTs).

Key Question 2a. Among publications that address adjunctive meditation as a treatment for adults with MDD, how common and severe are adverse events?

Five MBCT studies reported on adverse events and three stated that no adverse events occurred. One study reported that none of the adverse events were deemed to be related to the treatment but one participant in the MBCT group contacted the therapist during a suicidal crisis and after crisis intervention was referred to their psychiatrist. The fifth study reported that 15 serious adverse events occurred, only one of which was thought to be related to the study interventions (the event occurred in the CBT arm). None of the studies stated whether the occurrence of adverse events was systematically assessed. The lack of systematic assessment of adverse events and small sample size of individual studies reduces the ability to draw conclusions, however, as rare adverse events would be unlikely to be reported.

Key Question 2b. Does the efficacy differ depending on the type meditation used?

There was insufficient evidence to answer this question. A meta-regression analyzing differences between studies following the original MBCT manual versus studies that used a modified MBCT intervention indicated deviations were not significantly associated with MBCT results. One study showed that relapse rates did not differ between therapists of different background who were trained in MBCT and determined to be competent instructors.

In individuals with recurrent depression, one study found a weak correlation between the amount of formal meditation practiced outside the class and change in depressive symptom score during MBCT. Another study of individuals with recurrent depression found relapse rates were higher among individuals with more body scan practice six to twelve months after MBCT, but no associations with other forms of practice.

Key Question 3. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with MDD?

One fair quality study with 84 participants compared the effect on relapse rates at 18 months following treatment of MBCT to two control groups: 1) antidepressants and 2) placebo plus clinical management in a sample in remission with a history of at least three previous episodes of depression. Overall, there were no significant differences in relapse rates between either MBCT plus antidepressants (RR=0.80, 95% CI [0.39, 1.62]) or between monotherapy MBCT and

placebo plus clinical management (RR=0.65, 95% CI [0.34, 1.62]). Among those in stable remission, there were no significant differences in relapse rates between either MBCT plus antidepressants (RR=1.25, 95% CI [0.60, 2.59]), or between monotherapy MBCT and placebo plus clinical management (RR=1.06, 95% CI [0.54, 2.07]). Among those in unstable remission, MBCT was associated with lower relapse rate compared to placebo plus clinical management (RR=0.39, 95% CI [0.17, 0.88]), but not compared to antidepressants (RR=1.02, 95% CI [0.30, 3.45]).

Key Question 3a. Does the efficacy differ depending on the type meditation used?

The monotherapy study that reported on depression relapse followed the standard MBCT protocol and did not report on associations between meditation characteristics (e.g., frequency outside of class) and the occurrence of relapse. Hence there is insufficient evidence to address this question.

Key Question 4. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in decreasing relapse rates in adults with MDD?

We did not identify any study that reported on patients with MDD at the time of enrollment who were randomized to MBCT reporting on long-term follow-up to assess later relapse after initial treatment response. We identified six RCTs that addressed MBCT as an adjunct treatment that included an assessment of relapse. There was moderate quality evidence that adjunctive MBCT reduces relapse rates compared to all controls (RR 0.72; 95% CI [0.56, 0.93]; I^2 25%; 6 RCTs) and compared to TAU (RR 0.70; 95% CI 0.50, 0.98; I^2 39%; 5 RCTs). Only one study compared relapse rates of MBCT compared to maintenance medication (RR 0.80; 95% CI 0.57, 1.11) or CPE (RR 0.93, 95% CI 0.70, 1.24). Among patients with at least three prior episodes of depression in at least partial recovery, there was moderate evidence of the impact of adjunctive MBCT on relapse rates (RR=0.66, 95% CI [0.48, 0.90] I^2 47%, 6 RCTs). However, the evidence does not support that MBCT reduces relapse rates among individuals with one or two previous depressive episodes (RR =1.96, 95% CI [0.31, 12.29] I^2 0%; 2 RCTs).

Key Question 4a. Does the efficacy differ depending on the type meditation used?

There was insufficient evidence to answer this question. A meta-regression analyzing differences between studies following the original MBCT manual versus studies that used a modified MBCT intervention indicated deviations were not significantly associated with MBCT results. A study of individuals with recurrent depression found relapse rates were higher among individuals with more body scan practice six to twelve months after MBCT, but no associations with other forms of practice. Another study of individuals with recurrent depression found no difference in relapse rates between two trained MBCT instructors of different backgrounds, a clinical psychologist and an occupational therapist.

Key Question 5. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving HR-QOL symptoms in adults with MDD?

We did not identify any study that assessed whether monotherapy MBCT was associated with improved health-related quality of life among adults with MDD.

Key Question 6. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in improving HR-QOL symptoms in adults with MDD?

Five studies examined the effect of adjunctive MBCT on HR-QOL; TAU was the only comparator used in more than one study. Overall, there was very low quality evidence of the effect of MBCT on HR-QOL. The pooled estimate showed no significant differences in quality of life in the MBCT groups compared to control (SMD -0.42; 95% CI -0.70, -0.14; I^2 71%; 5 RCTs).

Key Question 7. Is meditation, as a monotherapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with MDD?

None of the monotherapy studies examined the effect of MBCT on the use of antidepressants.

Key Question 8. Is meditation, as an adjunctive therapy, more effective than treatment as usual, wait-lists, no-treatment, or other active treatments in reducing antidepressant use in adults with MDD?

Six studies of good and fair quality were identified that examined the impact of adjunctive MBCT on antidepressant use. Four studies found no significant differences in use or reinstatement of antidepressants over time or between groups. The pooled estimate showed no statistically significant differences in antidepressant use in the MBCT groups compared to control (RR -0.01; 95% CI -0.34, 0.32; I^2 18%; 4 RCTs). A fifth study found no statistically significant differences in changes in antidepressant use compared to TAU (14 percent in MBCT plus TAU versus 50 percent in TAU group). There is moderate evidence that MBCT does not affect antidepressant use. The sixth study found the cost of antidepressants was \$103 less (95% CI -\$191 to -\$14) in the MBCT group than maintenance antidepressant group over a fifteen month period.

Table 4.1: Quality of Evidence and Summary of Findings for MBCT

Outcome	Study Design of Studies and Participants	Findings: Direction/ Magnitude of Effect	Study Limitations (Study Quality; RoB)	Inconsistency	Indirectness	Imprecision	GRADE
Key Question 1: Monotherapy meditation and depressive symptoms							
Comparison: MBCT versus waitlist (Britton et al 2010)	1 RCT 26 enrolled, 20 completed	Study showed greater reduction in depressive symptoms in MBCT compared to waitlist SMD -1.11, 95% CI -2.07, -0.15	1 poor quality study (-2)	No replication (-1)	Direct	Precise	Very Low
Key Question 1a: Monotherapy meditation and adverse events							
Comparison: MBCT versus waitlist	1 RCT 26 enrolled, 20 completed	No adverse events occurred	1 poor quality studies (-2); study size too small to detect rare events	No replication (-1)	Direct	Imprecise (-1)	Very low
Key Question 1b. Does the efficacy differ depending on the characteristics of monotherapy meditation used?	1 RCT 26 enrolled, 20 completed	The study reported no correlation between depression scale scores and mindfulness meditation practice outside of class.	1 poor quality studies (-2)	No replication (-1)	Indirect	Unclear	Insufficient
Key Question 2: Adjunctive meditation and depressive symptoms							
Comparison: MBCT versus all comparators, MDD	7 RCTs 609 enrolled, 554 completed	SMD -0.80, 95% CI -1.29, -0.31	Mixed quality	Mostly positive results, but substantial heterogeneity (-1)	Direct	Precise	Moderate
Comparison: MBCT versus all comparators, current MDD and history of MDD	12 RCTs 1,057 enrolled, 910 completed	SMD -0.72, 95% CI -1.14, -0.30	Mixed quality	Mostly consistent in direction, but substantial heterogeneity (-1)	Direct	Precise	Moderate
Comparison: MBCT versus all comparators, history of MDD	5 RCTs 518 enrolled, 430 completed	SMD -0.57, 95% CI -1.67, 0.53	Mixed, but mostly poor quality studies (-1)	Mostly consistent in direction, but	Direct	Imprecise (-1)	Very low

Outcome	Study Design of Studies and Participants	Findings: Direction/ Magnitude of Effect	Study Limitations (Study Quality; RoB)	Inconsistency	Indirectness	Imprecision	GRADE
				substantial heterogeneity (-1)			
Comparison: MBCT plus TAU versus TAU, MDD	5 RCTs 522 enrolled, 493 completed	SMD -0.92, 95% CI -1.57, -0.27	Mixed, but mostly poor quality studies (-1)	Substantial heterogeneity (-1)	Direct	Precise	Low
Comparison: MBCT plus antidepressants versus antidepressants	1 RCT 123 enrolled, 104 completed	SMD of HRSD not significant SMD -0.30, 95% CI -0.66, 0.05	1 Fair quality study (-1)	No replication (-1) Mixed results depending on measure of depression (HRSD significant; BDI not significant).	Direct	Imprecise (-1)	Very low
Comparison: MBCT plus TAU versus CBT plus TAU	2 RCTs 159 enrolled, 135 completed	No differences between groups in either study Pooled SMD -0.06, 95% CI -1.01, 0.89	2 poor quality studies (-1)	Consistent	Direct	Imprecise (-1)	Very low
Comparison: MBCT plus antidepressant versus psycho-education plus antidepressant	1 RCT 18 enrolled, 16 completed	No difference between groups SMD -0.81, 95% CI -1.83, 0.22	1 fair quality study (-1)	No replication (-1)	Direct	Imprecise (-1)	Very low
Key Question 2a: Adjunctive meditation and adverse events							
Comparison: MBCT vs all comparators	5 RCTs 610 enrolled, 581 completed	3 RCTs reported no adverse events occurred. 1 RCT reported none of the adverse events were related to the intervention. 1 RCT reported 15 adverse events, but only one in a comparator arm was potentially related to the study	Mostly fair and poor studies (-1); Studies do not state whether occurrence of adverse events were systematically assessed	Consistent	Direct	Imprecise; studies too small to detect rare events (-1)	Low
Key Question 2b. Does	15 RCTs	A meta-regression did	Not systematically	Unclear (-1)	Indirect	Imprecise	Insuffi-

Outcome	Study Design of Studies and Participants	Findings: Direction/ Magnitude of Effect	Study Limitations (Study Quality; RoB)	Inconsistency	Indirectness	Imprecision	GRADE
the efficacy differ depending on the type of adjunctive meditation used?	1,551 enrolled, 1,370 completed	not indicate that manual deviations were associated with treatment results. One study found a weak correlation between the amount formal meditation practiced outside the class and change in depressive symptom scores. Another study found relapse rates were higher among individuals with more body scan practice six to twelve months after MBCT, but no associations with other forms of practice.	assessed (-1)			(-1)	cient
Key Question 3: Monotherapy meditation and depression relapse							
Comparison: MBCT versus placebo plus clinical management	1 RCT 56 enrolled, 56 completed	No significant differences between groups RR 0.65, 95% CI 0.34, 1.62	1 fair quality study (-1)	No replication (-1)	Direct	Imprecise (-1)	Very low
Comparison: MBCT versus antidepressants	1 RCT 54 enrolled, 54 completed	No significant differences between groups RR 0.80, 95% CI 0.39, 1.62	1 fair quality study (-1)	No replication (-1)	Direct	Imprecise (-1)	Very low
Key Question 4: Adjunctive meditation and depression relapse							
Comparison: MBCT versus all comparators	6 RCTs 783 enrolled, 695 completed	RR 0.72, 95% CI 0.56, 0.93	Mix of good, fair and poor (-1)	Consistent	Direct	Precise	Moderate
Comparison: MBCT versus all TAU	5 RCTs 550 enrolled, 488 completed	RR 0.70; 95% CI 0.50, 0.98	Mix of good, fair and poor (-1)	Consistent	Direct	Precise	Moderate
Comparison: MBCT	1 RCT	RR 0.80; 95% CI 0.57,	1 fair study (-1)	No replication	Direct	Precise	Low

Outcome	Study Design of Studies and Participants	Findings: Direction/ Magnitude of Effect	Study Limitations (Study Quality; RoB)	Inconsistency	Indirectness	Imprecision	GRADE
versus maintenance antidepressant	123 enrolled, 104 completed	1.11		(-1)			
Comparison: MBCT versus CPE	1 RCT 218 enrolled, 202 completed	RR 0.93, 95% CI 0.70, 1.24	1 poor study (-2)	No replication (-1)	Direct	Precise	Very low
Key Question 5: Monotherapy meditation and health-related quality of life	0 RCTs	NA	NA	NA	NA	NA	No evidence
Key Question 6: Adjunctive meditation and health-related quality of life							
Comparison: MBCT versus all comparators	5 studies 535 enrolled, 446 completed	Mixed results. SMD -0.42, 95% CI -0.70, -0.14	Fair and poor quality studies (-1)	Inconsistent (-1)	Direct	Imprecise (-1)	Very low
Comparison: MBCT versus TAU	2 studies 325 enrolled, 281 completed	One study found MBCT associated with improved quality of life (SMD -1.02; 95% CI -1.42, -0.61) the other study found MBCT was associated with better scores on the WHO Quality of Life psychological subscale compared to TAU (SMD -0.38; 95% CI -0.66, -0.11), but not the physical subscale (SMD -0.42, 95% CI -0.70, -0.14) or social subscale (SMD -0.09; 95% CI -0.36, 0.18)	1 poor and 1 fair quality study (-1)	Inconsistent (-1) Mixed results	Direct	Imprecise (-1)	Very low
Comparison: MBCT versus psycho-education	1 study 18 enrolled, 16 completed	Significantly larger improvements in HR-QOL with MBCT SMD -0.81; 95% CI -1.84, -0.22	1 fair quality study (-1)	No replication (-1)	Direct	Imprecise (-1)	Very low
Comparison: MBCT	1 study	No significant	1 poor quality	No replication	Direct	Imprecise (-1)	Very low

Outcome	Study Design of Studies and Participants	Findings: Direction/ Magnitude of Effect	Study Limitations (Study Quality; RoB)	Inconsistency	Indirectness	Imprecision	GRADE
versus CBT	69 enrolled, 45 completed	differences between MBCT and CBT: SMD 0.04, 95% CI -0.63, 0.56	study (-2)	(-1)		1)	
Comparison: MBCT versus maintenance antidepressants	1 study 123 enrolled 104 completed	There were not significant differences in QOL at one-month post-treatment between MBCT and maintenance antidepressants in the physical (SMD -0.10, 95% CI -0.46, 0.25), psychological (SMD -0.16, 95% CI -0.51, 0.19) or social (SMD -0.21, 95% CI -0.56, 0.15) domains of the WHO-QOL	1 fair study (-1)	No replication (-1)	Direct	Imprecise (-1)	Very low
Key Question 7: Monotherapy meditation and reduction in antidepressant use	0 RCTs	NA	NA	NA	NA	NA	No evidence
Key Question 8: Adjunctive meditation and antidepressant use							
Comparison: MBCT versus TAU	5 RCTs 417 enrolled, 364 completed	Four studies compared antidepressant use between MBCT group and controls. No significant differences in use of antidepressants between MBCT and controls: RR -0.01; 95% CI -0.34, 0.32. One study compared antidepressant changes	4 good and 1 fair quality studies	Consistent	Direct	Imprecise (-1)	Moderate

Outcome	Study Design of Studies and Participants	Findings: Direction/ Magnitude of Effect	Study Limitations (Study Quality; RoB)	Inconsistency	Indirectness	Imprecision	GRADE
		between MBCT plus TAU versus TAU (14 percent in MBCT plus TAU versus 50 percent in TAU group, p=0.052)					

Other Reviews in this Area

Previous reviews of MBCT (Chiesa and Serretti, 2011; Coelho, Canter and Ernst, 2007) included a smaller number of studies, which reflects the emerging evidence base related to MBCT. Coelho and colleagues (2007) focused on whether MBCT could reduce depression relapse among individuals with three or more previous episodes of depression. The review by Chiesa and Serretti (2011) examined both relapse and depressive symptoms, but did not restrict the included studies to those focusing on an MDD sample. Consistent with our findings, both reviews concluded that MBCT in addition to usual care can reduce major depression relapse among those with at least three previous depressive episodes compared to usual care alone. Also consistent with our findings, Chiesa and Serretti (2011) concluded that adjunctive MBCT could reduce residual depressive symptoms in patients with MDD. We expanded on previous reviews by analyzing data separately for monotherapy and adjunctive MBCT, as well as separately examining available information for those with active depression and those in remission.

Strengths and Limitations

This review has a number of strengths including a comprehensive search of electronic databases, the use of two independent reviewers to perform study selection and data abstraction, and the assessment of risk of bias and quality of evidence to develop the review's conclusions. Furthermore, we contacted investigators of recently completed registered trials to inquire about completed work that had not yet been published. This review systematically documents the available evidence on MBCT for MDD, the condition which is the focus of the VA/DoD clinical guidelines, rather than depressive disorders more broadly, and assesses the quality of evidence by specific outcomes. However, there are also some limitations that are worth noting. We did not request study authors to provide data beyond what was contained in publications or in-press manuscripts. Many of the articles had small samples and were of poor quality, largely due to lack of ITT, poor follow-up, or baseline differences between study arms. Thus, poor quality of the underlying studies limits the ability to draw strong conclusions about the effect of MBCT on depression.

Implications for Future Research and Practice

The existing evidence is primarily based on adjunctive therapy studies. There is insufficient evidence on the use of monotherapy MBCT to make conclusions about its efficacy, either to reduce depressive symptoms among those who are currently depressed or among those with a history of depression to reduce relapse. These are areas where additional studies are needed. There is also insufficient evidence on the effect of MBCT on HR-QOL. Few studies examined the effect of MBCT on measures of HR-QOL and there was a lack of consistency in comparators

used and the measures of HR-QOL included. There is a lack of standardized reporting of adverse events.

Future studies should improve on the weaknesses pervasive in the current body of work including, suboptimal participant retention, and the lack of true intention-to-treat analyses. Further research examining the effect of MBCT on depression should include samples large enough to allow results to be stratified by disease severity, include measures of HR-QOL and systematically assess adverse events.

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Spijker, J., R. De Graaf, R. V. Bijl, A. T. F. Beekman, J. Ormel, and W. A. Nolen, "Duration of major depressive episodes in the general population: Results from the Netherlands mental health survey and incidence study (NEMESIS)," *British Journal of Psychiatry*, Vol. 181, 2002, pp. 208-213.

Su, D., and L. Lifeng, "Trends in the use of complementary and alternative medicine in the United States: 2002-2007," *Journal of Health Care for the Poor and Underserved*, Vol. 22, No. 1, 2011, pp. 296-310.

Teasdale, J. D. Moore, R. G., Hayhurst, H. Pope, M., Williams, S. and Segal, Z. V. . Metacognitive awareness and prevention of relapse in depression: empirical evidence. *Journal of Consulting and Clinical Psychology*, 2002, 70 (2): 275–287.

Teasdale, J. D., Z. V. Segal, J. M. Williams, V. A. Ridgeway, J. M. Soulsby, and M. A. Lau, "Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy," *Journal of Consulting and Clinical Psychology*, Vol. 68, No. 4, Aug, 2000, pp. 615-623.

The Lewin Group and ECRI Institute, *Management of dyslipidemia: Evidence synthesis report. Clinical practice guideline*, Washington, DC: Veterans Health Administration, U.S. Department of Veterans Affairs, and the U.S. Department of Defense, 2014.

The Management of MDD Working Group, *VA/DoD clinical practice guideline for management of major depressive disorder*, Washington, D.C.: Department of Veterans Affairs, May, 2009. http://www.healthquality.va.gov/mdd/mdd_full09_c.pdf

Tylee, A., and R. Jones, "Managing depression in primary care: Public confidence needs to be restored after concerns over the safety of SSRIs," *BMJ: British Medical Journal*, Vol. 330, No. 7495, 2005, pp. 800–801.

US Preventive Services Task Force, *US preventive services task force procedure manual*, Rockville, MD: Agency for Healthcare Research and Quality, 2008.

Van Aalderen, J. R., A. R. Donders, F. G. M. G. G. M. P. Spinhoven, H. P. Barendregt, and A. E. Speckens, "The efficacy of mindfulness-based cognitive therapy in recurrent depressed patients with and without a current depressive episode: A randomized controlled trial," *Psychological Medicine*, Vol. 42, No. 5, May, 2012, pp. 989-1001.

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Vaughan, C. A., T. L. Schell, L. H. Jaycox, G. N. Marshall, and T. Tanielian, *Quantitative needs assessment of new york state veterans and their spouses,* in terry l. Schell and terri tanielian, eds., *a needs assessment of new york state veterans: Final report to the new york state health foundation*, Santa Monica, CA: RAND Corporation, TR-920-NYSHF, 2011.
http://www.rand.org/pubs/technical_reports/TR920.html.html

Vogt, D., "Mental health-related beliefs as a barrier to service use for military personnel and veterans: A review," *Psychiatric Services*, Vol. 62, No. 2, 2011, pp. 135-142.

Wells, T., C. L. Mann, S. Fortuna, B. Smith, T. C. Smith, M. a. K. Ryan, E. J. Boyko, and D. Blazer, "A prospective study of depression following combat deployment in support of the wars in Iraq and Afghanistan," *American Journal of Public Health*, Vol. 100, No. 1, 2010, pp. 90-99.

Williams, A. L., A. J. Holmes, J. Dixon, and R. Mccorkle, "Factors associated with depressive symptoms in cancer family caregivers of patients receiving chemotherapy," *Supportive Care in Cancer*, Vol. 21, No. 9, Sep, 2013, pp. 2387-2394.

Williams, J. M. G., C. Crane, T. Barnhofer, K. Brennan, D. S. Duggan, M. J. Fennell, A. Hackmann, A. Krusche, K. Muse, and I. R. Von Rohr, "Mindfulness-based cognitive therapy for preventing relapse in recurrent depression: A randomized dismantling trial," *Journal of Consulting and Clinical Psychology*, Vol. 82, No. 2, 2014, p. 275.

Williams, J. M. G., Teasdale, John D., Segal, Zindel V., and Soulsby, Judith. (2000). Mindfulness-based cognitive therapy reduces overgeneral autobiographical memory in formerly depressed patients. *Journal of Abnormal Psychology*, 109(1), 150-155. doi: 10.1037/0021-843X.109.1.150

Zinzow, H. M., T. W. Britt, A. C. Mcfadden, C. M. Burnette, and S. Gillispie, "Connecting active duty and returning veterans to mental health treatment: Interventions and treatment adaptations that may reduce barriers to care," *Clinical Psychology Review*, Vol. 32, No. 8, 2012, pp. 741-753.

Our search strategy for each database used the key words presented in Chapter 2. Here we present as an example of the specific strategies, our search strategy specifications for PubMed.

PubMed

Limits: English; Not: Editorial or Comment; through January 2015

(depress* OR depression[MeSH] OR “depressive disorder”[MeSH] OR “mood disorders”[MeSH] OR “mood disorder” OR “Mood disorders” OR “depressive disorder” OR “depressive disorders” OR (“mood” [Title/Abstract] AND “disturbance”[Title/Abstract]) OR “affective disorders” OR “affective disorder”)

AND

(Meditation OR “mental training” OR “open monitoring meditation” OR “mindfulness” OR “mindful” OR “mindfulness-based stress reduction” OR Zen OR Vipassana OR Sahaja OR “Mindfulness-based cognitive therapy” OR “mindfulness based relapse prevention” OR “mindful attention”)

OR

(“focused”[Title/abstract] AND “attention”[Title/Abstract] AND (“meditations”[Title/Abstract] OR “mediation”[Title/Abstract])) OR “compassion meditation” OR “loving kindness” OR metta OR tonlen OR “qigong” OR “Qi Gong”)

OR

(“automatic” [Title/abstract] AND “self-transcending” [Title/abstract] AND “meditation” [Title/abstract]) OR (“Mantra”[Title/abstract] AND (“meditations” [Title/abstract] OR “mantra meditation” [Title/abstract]) OR (“mantram” [Title/abstract] AND “repetition” [Title/abstract] AND “program” [Title/abstract]) OR “transcendental meditation” OR “relaxation response training”)

OR

(“movement”[Title/Abstract] AND (“meditation”[Title/Abstract] OR “meditations”[Title/Abstract])) OR yoga OR “tai chi” OR “meditative movement” OR yoga[MeSH])

OR

(zazen OR (“one-pointed”[Title/Abstract] AND “meditation”[Title/Abstract]) OR “progressive muscle relaxation”)

Web of Science

Refined by: Languages=(ENGLISH) AND [excluding] Document Types=(EDITORIAL

MATERIAL OR LETTER OR NEWS ITEM OR BOOK REVIEW)

Timespan=2014-2015. Databases=SCI-EXPANDED, SSCI, A&HCI.

depress* OR "mood disorder" OR "Mood disorders" OR "depressive disorder" OR
"depressive disorders" OR "mood disturbance" OR "affective disorders" OR "affective disorder"

AND

Meditation OR "mental training" OR "open monitoring meditation" OR mindfulness OR
mindful OR "mindfulness-based stress reduction" OR Zen OR Vipassana OR Sahaja OR
"Mindfulness-based cognitive therapy" OR "mindfulness based relapse prevention" OR
"mindful attention"

OR

"focused attention meditations" OR "focused attention meditation" OR "compassion meditation"
OR "compassion meditations" OR "loving kindness" OR metta OR tonlen OR qigong OR "Qi
Gong"

OR

"automatic self-transcending meditations" OR "automatic self-transcending meditation" OR
"Mantra meditations" OR "mantra meditation" OR "mantram repetition program" OR
"transcendental meditation" OR "relaxation response training"

OR

"movement meditation" OR "movement meditations" OR yoga OR "tai chi" OR "meditative
movement"

OR

zazen OR "one-pointed meditation" OR "progressive muscle relaxation"

EMBASE

**English; not ('conference abstract'/it OR 'conference review'/it OR 'editorial'/it OR
'letter'/it OR 'note'/it)**

depress* OR "mood disorder" OR "Mood disorders" OR "depressive disorder" OR
"depressive disorders" OR "mood disturbance" OR "affective disorders" OR "affective disorder"

AND

Meditation OR "mental training" OR "open monitoring meditation" OR mindfulness OR
mindful OR "mindfulness-based stress reduction" OR Zen OR Vipassana OR Sahaja OR
"Mindfulness-based cognitive therapy" OR "mindfulness based relapse prevention" OR
"mindful attention"

OR

"focused attention meditations" OR "focused attention meditation" OR "compassion meditation"
OR "compassion meditations" OR "loving kindness" OR metta OR tonlen OR qigong OR "Qi
Gong"

OR

“automatic self-transcending meditations” OR “automatic self-transcending meditation” OR
“Mantra meditations” OR “mantra meditation” OR “mantram repetition program” OR
“transcendental meditation” OR “relaxation response training”

OR

“movement meditation” OR “movement meditations” OR yoga OR “tai chi” OR “meditative
movement”

OR

zazen OR “one-pointed meditation” OR “progressive muscle relaxation”

CINAHL

English; Academic Journals

depress* OR “mood disorder” OR “Mood disorders” OR “depressive disorder” OR “depressive
disorders” OR “mood disturbance” OR “affective disorders” OR “affective disorder”

AND

Meditation OR “mental training” OR “open monitoring meditation” OR mindfulness OR
mindful OR “mindfulness-based stress reduction” OR Zen OR Vipassana OR Sahaja OR
“Mindfulness-based cognitive therapy” OR “mindfulness based relapse prevention” OR
“mindful attention”

OR

“focused attention meditations” OR “focused attention meditation” OR “compassion meditation”
OR “compassion meditations” OR “loving kindness” OR metta OR tonlen OR qigong OR “Qi
Gong”

OR

“automatic self-transcending meditations” OR “automatic self-transcending meditation” OR
“Mantra meditations” OR “mantra meditation” OR “mantram repetition program” OR
“transcendental meditation” OR “relaxation response training”

OR

“movement meditation” OR “movement meditations” OR yoga OR “tai chi” OR “meditative
movement”

OR

zazen OR “one-pointed meditation” OR “progressive muscle relaxation”

PsycInfo

English; Peer Reviewed Journals

depress* OR “mood disorder” OR “Mood disorders” OR “depressive disorder” OR “depressive disorders” OR “mood disturbance” OR “affective disorders” OR “affective disorder”

AND

OM

Meditation OR “mental training” OR “open monitoring meditation” OR mindfulness OR mindful OR “mindfulness-based stress reduction” OR Zen OR Vipassana OR Sahaja OR “Mindfulness-based cognitive therapy” OR “mindfulness based relapse prevention” OR “mindful attention”

OR

“focused attention meditations” OR “focused attention meditation” OR “compassion meditation” OR “compassion meditations” OR “loving kindness” OR metta OR tonlen OR qigong OR “Qi Gong”

OR

“automatic self-transcending meditations” OR “automatic self-transcending meditation” OR “Mantra meditations” OR “mantra meditation” OR “mantram repetition program” OR “transcendental meditation” OR “relaxation response training”

OR

“movement meditation” OR “movement meditations” OR yoga OR “tai chi” OR “meditative movement”

OR

zazen OR “one-pointed meditation” OR “progressive muscle relaxation”

Cochrane

Abstract, Title, Keyword search

depress* OR “mood disorder” OR “Mood disorders” OR “depressive disorder” OR “depressive disorders” OR “mood disturbance” OR “affective disorders” OR “affective disorder”

AND

OM

Meditation OR “mental training” OR “open monitoring meditation” OR mindfulness OR mindful OR “mindfulness-based stress reduction” OR Zen OR Vipassana OR Sahaja OR “Mindfulness-based cognitive therapy” OR “mindfulness based relapse prevention” OR “mindful attention”

OR

“focused attention meditations” OR “focused attention meditation” OR “compassion meditation” OR “compassion meditations” OR “loving kindness” OR metta OR tonlen OR qigong OR “Qi

Gong”

OR

“automatic self-transcending meditations” OR “automatic self-transcending meditation” OR
“Mantra meditations” OR “mantra meditation” OR “mantram repetition program” OR
“transcendental meditation” OR “relaxation response training”

OR

“movement meditation” OR “movement meditations” OR yoga OR “tai chi” OR “meditative
movement”

OR

zazen OR “one-pointed meditation” OR “progressive muscle relaxation”

PILOTS

depress* OR “mood disorder” OR “Mood disorders” OR “depressive disorder” OR “depressive
disorders” OR “mood disturbance” OR “affective disorders” OR “affective disorder”

AND

Meditation OR “mental training” OR “open monitoring meditation” OR mindfulness OR
mindful OR “mindfulness-based stress reduction” OR Zen OR Vipassana OR Sahaja OR
“Mindfulness-based cognitive therapy” OR “mindfulness based relapse prevention” OR
“mindful attention”

OR

“focused attention meditations” OR “focused attention meditation” OR “compassion meditation”
OR “compassion meditations” OR “loving kindness” OR metta OR tonlen OR qigong OR “Qi
Gong”

OR

“automatic self-transcending meditations” OR “automatic self-transcending meditation” OR
“Mantra meditations” OR “mantra meditation” OR “mantram repetition program” OR
“transcendental meditation” OR “relaxation response training”

OR

“movement meditation” OR “movement meditations” OR yoga OR “tai chi” OR “meditative
movement”

OR

zazen OR “one-pointed meditation” OR “progressive muscle relaxation”

Mindfulness-based cognitive therapy

Update 15 May 2015

PubMed

Filters: Randomized Controlled Trial; Publication date from 2006/01/01 to 2014/12/31; English

“mbct” OR “m-bct” OR “mindfulness based cognitive therapy” OR “mindfulness-based CT”
OR mindfulness based cognitive therapy

AND

(depress* OR depression[MeSH] OR “depressive disorder”[MeSH] OR “mood disorders”[MeSH] OR “mood disorder” OR “Mood disorders” OR “depressive disorder” OR “depressive disorders” OR (“mood” [Title/Abstract] AND “disturbance”[Title/Abstract]) OR “affective disorders” OR “affective disorder”)

Results: 84 – duplicates=0

Web of Science

Refined by: [excluding] DOCUMENT TYPES: (EDITORIAL MATERIAL OR LETTER OR BOOK REVIEW) Indexes=SCI-EXPANDED, SSCI, A&HCI Timespan=2006-2014

“mbct” OR “m-bct” OR “mindfulness based cognitive therapy” OR “mindfulness-based CT”
OR mindfulness based cognitive therapy

AND

depress* OR “mood disorder” OR “Mood disorders” OR “depressive disorder” OR “depressive disorders” OR “mood disturbance” OR “affective disorders” OR “affective disorder”

Results: 458- duplicates = 41

Embase

[english]/lim AND [embase]/lim AND [2006-2014]/py

“mbct” OR “m-bct” OR “mindfulness based cognitive therapy” OR “mindfulness-based CT”
OR mindfulness based cognitive therapy

AND

depress* OR “mood disorder” OR “Mood disorders” OR “depressive disorder” OR “depressive disorders” OR “mood disturbance” OR “affective disorders” OR “affective disorder”

Results: 219 – duplicates =5

CINAHL

Date of Publication: 20060101-20141231; Exclude MEDLINE records; Language: English

“mbct” OR “m-bct” OR “mindfulness based cognitive therapy” OR “mindfulness-based CT”
OR mindfulness based cognitive therapy

AND

depress* OR "mood disorder" OR "Mood disorders" OR "depressive disorder" OR "depressive disorders" OR "mood disturbance" OR "affective disorders" OR "affective disorder"

Results: 12-duplicates = 0

PsycInfo

Limits - Date of Publication: 20060101-20141231; Publication Type: Peer Reviewed Journal;
Language: English

"mbct" OR "m-bct" OR "mindfulness based cognitive therapy" OR "mindfulness-based CT"
OR mindfulness based cognitive therapy

AND

depress* OR "mood disorder" OR "Mood disorders" OR "depressive disorder" OR "depressive disorders" OR "mood disturbance" OR "affective disorders" OR "affective disorder"

Results: 200-duplicates = 4

PILOTS

Limits: 2006-2014

"mbct" OR "m-bct" OR "mindfulness based cognitive therapy" OR "mindfulness-based CT"
OR mindfulness based cognitive therapy

AND

depress* OR "mood disorder" OR "Mood disorders" OR "depressive disorder" OR "depressive disorders" OR "mood disturbance" OR "affective disorders" OR "affective disorder"

Results: 11-duplicates = 1

Cochrane

Publication Year from 2006 to 2014

"mbct" OR "m-bct" OR "mindfulness based cognitive therapy" OR "mindfulness-based CT"
OR mindfulness based cognitive therapy

AND

depress* OR "mood disorder" OR "Mood disorders" OR "depressive disorder" OR "depressive disorders" OR "mood disturbance" OR "affective disorders" OR "affective disorder"

Results: 139 =-duplicates = 6

(CDSR:2; DARE:8; CENTRAL:127)

ClinicalTrials.gov

("mbct" OR "m-bct" OR "mindfulness based cognitive therapy" OR "mindfulness-based CT"
OR mindfulness based cognitive therapy)

AND

(depress* OR "mood disorder" OR "Mood disorders" OR "depressive disorder" OR "depressive disorders" OR "mood disturbance" OR "affective disorders" OR "affective disorder")

Results: 55

Appendix B: Publications Excluded During Full Text Review

Publication	Exclusion Reason
Abbott, R. and Lavretsky, H. (2013). Tai Chi and Qigong for the treatment and prevention of mental disorders. <i>Psychiatric Clinics of North America</i> , 36(1), 109-119.	Nonsystematic review
Ades, P. A., Savage, P., Cress, M. E., Brochu, M., Lee, N. M. and Poehlman, E. T. (2003). Resistance training on physical performance in disabled older female cardiac patients. <i>Medicine and Science in Sports and Exercise</i> , 35(8), 1265-1270. doi: 10.1249/01.mss.0000079044.21828.0e	Does not report data for MDD
Ades, P. A., Savage, P. D., Brochu, M., Tischler, M. D., Lee, N. M., and Poehlman, E. T. (2005). Resistance training increases total daily energy expenditure in disabled older women with coronary heart disease. <i>Journal of Applied Physiology</i> (1985), 98(4), 1280-1285. doi: 10.1152/jappphysiol.00360.2004	Does not report data for MDD
Afonso, R. F., Hachul, H., Kozasa, E. H., de Souza Oliveira, D., Goto, Rodrigues, V., Tufik S, Leite, J. R. (2012). Yoga decreases insomnia in postmenopausal women: a randomized clinical trial. <i>Menopause</i> , 19(2), 186-193. doi: 10.1097/gme.0b013e318228225f	Does not report data for MDD
Ahmadi, A., Arastoo, A. A., Nikbakht, M., Zahednejad, S., and Rajabpour, M. (2013). Comparison of the effect of 8 weeks aerobic and yoga training on ambulatory function, fatigue and mood status in MS patients. <i>Iranian Red Crescent Medical Journal</i> , 15(6), 449-454.	Does not report data for MDD
Alexander, J. L., Richardson, G., Grypma, L., & Hunkeler, E. M. (2007). Collaborative depression care, screening, diagnosis and specificity of depression treatments in the primary care setting. <i>Expert Review of Neurotherapeutics</i> , 7(11s), S59-S80.	Nonsystematic review
Alexander, V. L., and B. C. Tatum, "Effectiveness of Cognitive Therapy and Mindfulness Tools in Reducing Depression and Anxiety: A Mixed Method Study," <i>Psychology</i> , Vol. 5, No. 15, 2014, pp. 1702-1713. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2014-44521-002&site=ehost-live	Not limited to MDD
Allen, N. B., Blashki, G., Gullone, E., and Academic Mindfulness Interest Group, Melbourne, and Melbourne Academic Mindfulness Interest Group. (2006). Mindfulness-based psychotherapies: a review of conceptual foundations, empirical evidence and practical considerations. <i>Australian and New Zealand Journal of Psychiatry</i> , 40(4), 285-294.	Systematic review
Altschuler, A., Rosenbaum, E., Gordon, P., Canales, S., and Avins, A. L. (2012). Audio recordings of mindfulness-based stress reduction training to improve cancer patients' mood and quality of life--a pilot feasibility study. <i>Support Care Cancer</i> , 20(6), 1291-1297. doi: 10.1007/s00520-011-1216-7	Does not report data for MDD
Ando, M., Morita, T., Akechi, T., Ito, S., Tanaka, M., Ifuku, Y., and Nakayama, T. (2009). The efficacy of mindfulness-based meditation therapy on anxiety, depression, and spirituality in Japanese patients with cancer. <i>Journal of Palliative Medicine</i> , 12(12), 1091-1094. doi: 10.1089/jpm.2009.0143	Does not report data for MDD
Anells, S., and K. Kho, "Meditate Don't Medicate! How Medical Imaging Extends the Current Evidence That Meditation Should Play a Role in the Treatment of Depression," <i>Journal of Medical Imaging and Radiation Oncology</i> , Vol. 58, 2014, p. 86. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L71615323	Nonsystematic review

Publication	Exclusion Reason
Arch, J. J., Ayers, C. R., Baker, A., Almklov, E., Dean, D. J., and Craske, M. G. (2013). Randomized clinical trial of adapted mindfulness-based stress reduction versus group cognitive behavioral therapy for heterogeneous anxiety disorders. <i>Behaviour Research and Therapy</i> , 51(4-5), 185-196. doi: 10.1016/j.brat.2013.01.003	Does not report data for MDD
Arias, A. J., Steinberg, K., Banga, A., and Trestman, R. L. (2006). Systematic review of the efficacy of meditation techniques as treatments for medical illness. <i>Journal of Alternative and Complementary Medicine</i> , 12(8), 817-832. doi: 10.1089/acm.2006.12.817	Systematic review
Artemiadis, A. K., Vervainioti, A. A., Alexopoulos, E. C., Rombos, A., Anagnostouli, M. C., and Darviri, C. (2012). Stress management and multiple sclerosis: a randomized controlled trial. <i>Archives of Clinical Neuropsychology</i> , 27(4), 406-416. doi: 10.1093/arclin/acs039	Does not report data for MDD
Asbury, E. A., Kanji, N., Ernst, E., Barbir, M., and Collins, P. (2009). Autogenic training to manage symptomology in women with chest pain and normal coronary arteries. <i>Menopause-the Journal of the North American Menopause Society</i> , 16(1), 60-65. doi: 10.1097/gme.0b013e318184762e	Does not report data for MDD
Astin, J. A., Berman, B. M., Bausell, B., Lee, W. L., Hochberg, M., and Forys, K. L. (2003). The efficacy of mindfulness meditation plus Qigong movement therapy in the treatment of fibromyalgia: a randomized controlled trial. <i>Journal of Rheumatology</i> , 30(10), 2257-2262.	Does not report data for MDD
Balasubramaniam, M., Telles, S., and Doraiswamy, P. M. (2012). Yoga on our minds: a systematic review of yoga for neuropsychiatric disorders. <i>Front Psychiatry</i> , 3, 117. doi: 10.3389/fpsy.2012.00117	Systematic review
Banerjee, B., Vadiraj, H. S., Ram, A., Rao, R., Jayapal, M., Gopinath, K. S., Ramesh, B.S., Rao, N., Kumar, A., Raghuram, N., Hegde, S., Nagendra, H.R., Hande, M. P. (2007). Effects of an integrated yoga program in modulating psychological stress and Radiation-induced genotoxic stress in breast cancer patients undergoing radiotherapy. <i>Integrative Cancer Therapies</i> , 6(3), 242-250. doi: 10.1177/1534735407306214	Does not report data for MDD
Baraniak, A., and Sheffield, D. (2011). The efficacy of psychologically based interventions to improve anxiety, depression and quality of life in COPD: a systematic review and meta-analysis. <i>Patient Education and Counseling</i> , 83(1), 29-36. doi: 10.1016/j.pec.2010.04.010	Does not report data for meditation for MDD
Barling, N. R., and Raine, S. J. (2005). Some effects of hypnosis on negative affect and immune system response. <i>Australian Journal of Clinical and Experimental Hypnosis</i> , 33(2), 160-177.	Does not report data for MDD
Barnhofer, T., Chittka, T., Nightingale, H., Visser, C., and Crane, C. (2010). State effects of two forms of meditation on prefrontal EEG asymmetry in previously depressed individuals. <i>Mindfulness (N Y)</i> , 1(1), 21-27. doi: 10.1007/s12671-010-0004-7	Does not report data for MDD
Barnhofer, T., Duggan, D., Crane, C., Hepburn, S., Fennell, M. J., and Williams, J. M. (2007). Effects of meditation on frontal alpha-asymmetry in previously suicidal individuals. <i>Neuroreport</i> , 18(7), 709-712. doi: 10.1097/WNR.0b013e3280d943cd	Does not report data for MDD
Barraca, J. (2012). "Mental control" from a third-wave behavior therapy perspective. <i>International Journal of Clinical and Health Psychology</i> , 12(1), 109-121.	Systematic review

Publication	Exclusion Reason
Barrow, D. E., Bedford, A., Ives, G., O'Toole, L., and Channer, K. S. (2007). An evaluation of the effects of Tai Chi Chuan and Chi Kung training in patients with symptomatic heart failure: A randomised controlled pilot study. <i>Postgraduate Medical Journal</i> , 83(985), 717-721.	Does not report data for MDD
Baskin, S. M., and Smitherman, T. A. (2011). Comorbidity between migraine and depression: update on traditional and alternative treatments. <i>Neurological Sciences</i> , 32(SUPPL. 1), S9-S13.	Nonsystematic review
Battle, C. L., Uebelacker, L. A., Howard, M., and Castaneda, M. (2010). Prenatal yoga and depression during pregnancy. <i>Birth</i> , 37(4), 353-354. doi: 10.1111/j.1523-536X.2010.00435_1.x	Does not report data for meditation for MDD
Bauer-Wu, S., Sullivan, A. M., Rosenbaum, E., Ott, M. J., Powell, M., McLoughlin, M., and Healey, M. W. (2008). Facing the challenges of hematopoietic stem cell transplantation with mindfulness meditation: A pilot study. <i>Integrative Cancer Therapies</i> , 7(2), 62-69. doi: 10.1177/1534735408319068	Does not report data for MDD
Baum, C., Kuyken, W., Bohus, M., Heidenreich, T., Michalak, J., and Steil, R. (2010). The psychometric properties of the Kentucky inventory of mindfulness skills in clinical populations. <i>Assessment</i> , 17(2), 220-229. doi: 10.1177/1073191109356525	Does not report data for meditation for MDD
Bazzan, A. J., G. Zabrecky, D. A. Monti, and A. B. Newberg, "Current Evidence Regarding the Management of Mood and Anxiety Disorders Using Complementary and Alternative Medicine," <i>Expert Review of Neurotherapeutics</i> , Vol. 14, No. 4, Apr, 2014, pp. 411-423. <Go to ISI>://WOS:000335329800008 http://informahealthcare.com/doi/abs/10.1586/14737175.2014.892420	Systematic review
Bedard, M., Felteau, M., Marshall, S. Cullen, N., Gibbons, C., Dubois, S., Maxwell, H., Mazmanian, D., Weaver, B., Rees, L., Gainer, R., Klein, R. and Moustgaard, A. (2013). "Mindfulness-based cognitive therapy reduces symptoms of depression in people with a traumatic brain injury: results from a randomized controlled trial," <i>Journal of Head Trauma Rehabil.</i>	Does not report data for MDD
Bedard, M., Felteau, M., Marshall, S., Dubois, S., Gibbons, S., Klein, R. and Weaver, B. (2012). Mindfulness-based cognitive therapy: benefits in reducing depression following a traumatic brain injury. <i>Advances in Mind-Body Medicine</i> . 2012; 26(1):14-20.	Not RCT
Bedard, M., Felteau, M., Marshall, S., Dubois, S., Weaver, B., Gibbons, C., K. Morris, S. Ross, and B. Parker. (2008). Mindfulness-based cognitive therapy reduces depression symptoms in people with a traumatic brain injury: results from a pilot study. <i>European Psychiatry</i> , 23, S243-S243. doi: 10.1016/j.eurpsy.2008.01.464	Does not report data for MDD
Bedard, M., Felteau, M., Mazmanian, D., Fedyk, K., Klein, R., Richardson, J., and Minthorn-Biggs, M. B. (2003). Pilot evaluation of a mindfulness-based intervention to improve quality of life among individuals who sustained traumatic brain injuries. <i>Disability and Rehabilitation</i> , 25(13), 722-731. doi: 10.1080/0963828031000090489	Conference proceeding
Berman, B. M., and Singh, B. B. (1997). Chronic low back pain: an outcome analysis of a mind-body intervention. <i>Complementary Therapies in Medicine</i> , 5(1), 29-35.	Does not report data for MDD
Bertolin-Guillen, J. M., and Bertolin-Colilla, M. (2011). Effectiveness of mindfulness-based therapies as an alternative or adjuvant of antidepressants in the treatment of depression. <i>European Neuropsychopharmacology</i> , 21, S367-S368.	Conference proceeding

Publication	Exclusion Reason
Bertschy, G. B., Jermann, F., Bizzini, L., Weber-Rouget, B., Myers-Arrazola, M., and van der Linden, M. (2008). Mindfulness based cognitive therapy: a randomized controlled study on its efficiency to reduce depressive relapse/recurrence. <i>Journal of Affective Disorders</i> , 107, S59-S60. doi: 10.1016/j.jad.2007.12.023	Conference proceeding
Beshai, S., Dobson, K. S., Bockting, C. L., and Quigley, L. (2011). Relapse and recurrence prevention in depression: current research and future prospects. <i>Clinical Psychology Review</i> , 31(8), 1349-1360. doi: 10.1016/j.cpr.2011.09.003	Systematic review
Bhanji, Salena. (2011). Is it time we turn towards 'third wave' therapies to treat depression in primary care? A review of the theory and evidence with implications for counselling psychologists. <i>Counselling Psychology Review</i> , 26(2), 57-69.	Nonsystematic review
Bhatia, T., Agarwal, A., Shah, G., Wood, J., Richard, J., Gur, R. E., Nimgaonkar, V., Mazumdar, S., and Deshpande, S. N. (2012). Adjunctive cognitive remediation for schizophrenia using yoga: an open, non-randomized trial. <i>Acta Neuropsychiatrica</i> , 24(2), 91-100. doi: 10.1111/j.1601-5215.2011.00587.x	Does not report relevant outcome data
Bishop, S. R. (2002). What do we really know about mindfulness-based stress reduction? <i>Psychosomatic Medicine</i> , 64(1), 71-83.	Nonsystematic review
Blanchard, E. B., Andrasik, F., Evans, D. D., Neff, D. F., and Appelbaum, K. A. (1985). Behavioral treatment of 250 chronic headache patients: A clinical replication series. <i>Behavior Therapy</i> , 16(3), 308-327. doi: 10.1016/S0005-7894(85)80019-8	Does not report data for MDD
Bock, B. C., Fava, J. L., Gaskins, R., Morrow, K. M., Williams, D. M., Jennings, E., Becker, B., Tremont, G., and Marcus, B. H. (2012). Yoga as a complementary treatment for smoking cessation in women. <i>Journal of Women's Health (Larchmt)</i> , 21(2), 240-248. doi: 10.1089/jwh.2011.2963	Does not report data for MDD
Bockting, C. L. H. (2010). Breaking the rhythm of depression: cognitive behavior therapy and relapse prevention for depression. <i>Psihologiske Teme</i> , 19(2), 273-287.	Nonsystematic review
Bohlmeijer, E., Prenger, R., Taal, E., and Cuijpers, P. (2010). The effects of mindfulness-based stress reduction therapy on mental health of adults with a chronic medical disease: a meta-analysis. <i>Journal of Psychosomatic Research</i> , 68(6), 539-544. doi: 10.1016/j.jpsychores.2009.10.005	Systematic review
Bonadonna, R. (2003). Meditation's impact on chronic illness. <i>Holistic Nursing Practice</i> , 17(6), 309-319.	Nonsystematic review
Bormann, J. E., Gifford, A. L., Shively, M., Smith, T. L., Redwine, L., Kelly, A., Becker, S., Gershwin, M., Bone, P., and Belding, W. (2006). Effects of spiritual mantram repetition on HIV outcomes: A randomized controlled trial. <i>Journal of Behavioral Medicine</i> , 29(4), 359-376. doi: 10.1007/s10865-006-9063-6	Does not report data for MDD
Bormann, J. E., Thorp, S. R., Wetherell, J. L., Golshan, S., and Lang, A. J. (2013). Meditation-based mantram intervention for Veterans with posttraumatic stress disorder: a randomized trial. <i>Psychological Trauma-Theory Research Practice and Policy</i> , 5(3), 259-267. doi: 10.1037/a0027522	Does not report data for MDD
Bos, E.H. Merea, R., van den Brink, E., Sanderman, R., Bartels-Velthuis, A.A. (2014). Mindfulness Training in a Heterogeneous Psychiatric Sample: Outcome Evaluation and Comparison of Different Diagnostic Groups <i>J. Clin. Psychol.</i> , 70:60–71.	Not RCT
Bostanov, V., Hautzinger, M., and Kotchoubey, B. (2007). Event-related potentials validate attentional changes after mindfulness training in chronic depression. <i>Psychophysiology</i> , 44, S28-S29.	Conference proceeding

Publication	Exclusion Reason
Boteva, K. (2008). Mindfulness meditation in patients with mood disorders. Feasibility, safety and efficacy: an empirical review. <i>International Journal of Child Health and Human Development</i> , 1(2), 135-154.	Systematic review
Bower, J. E., Garet, D., Sternlieb, B., Ganz, P. A., Irwin, M. R., Olmstead, R., and Greendale, G. (2012). Yoga for persistent fatigue in breast cancer survivors: a randomized controlled trial. <i>Cancer</i> , 118(15), 3766-3775. doi: 10.1002/cncr.26702	Does not report data for MDD
Bowers, W.A. (1990). Treatment of depressed in-patients. Cognitive therapy plus medication, relaxation plus medication, and medication alone. <i>British Journal of Psychiatry</i> , 156, 73-78.	Does not report data for meditation for MDD
Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., and Gilbert, P. (2013). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. <i>British Journal of Clinical Psychology</i> , 52, 199-214. doi: 10.1111/bjc.12009	Does not report data for MDD
Branstrom, R., Kvillemo, P., and Moskowitz, J. T. (2012). A randomized study of the effects of mindfulness training on psychological well-being and symptoms of stress in patients treated for cancer at 6-month follow-up. <i>International Journal of Behavioral Medicine</i> , 19(4), 535-542. doi: 10.1007/s12529-011-9192-3	Does not report data for MDD
Brazier, A., Cooke, K., and Moravan, V. (2008). Using mixed methods for evaluating an integrative approach to cancer care: A case study. <i>Integrative Cancer Therapies</i> , 7(1), 5-17.	Does not report data for MDD
Britton, W. B., Haynes, P. L., Fridel, K. W., and Bootzin, R. R. (2012). Mindfulness-based cognitive therapy improves polysomnographic and subjective sleep profiles in antidepressant users with sleep complaints. <i>Psychotherapy and psychosomatics</i> , 81(5), 296-304. doi: 10.1159/000332755000332755	Does not report data for MDD
Britton, W. B., Shahar, B., Szepsenwol, O., and Jacobs, W. J. (2012). Mindfulness-based cognitive therapy improves emotional reactivity to social stress: results from a randomized controlled trial. <i>Behavior Therapy</i> , 43(2), 365-380. doi: 10.1016/j.beth.2011.08.006	Does not report relevant outcome data
Brooker, J., Julian, J., Webber, L., Chan, J., Shawyer, F., and Meadows, G. (2013). Evaluation of an occupational mindfulness program for staff employed in the disability sector in Australia. <i>Mindfulness</i> , 4(2), 122-136. doi: 10.1007/s12671-012-0112-7	Does not report data for MDD
Brooks, J. S., and Scarano, T. (1985). Transcendental meditation in the treatment of post-Vietnam adjustment. <i>Journal of Counseling and Development</i> , 64(3), 212-215. doi: 10.1002/j.1556-6676.1985.tb01078.x	Does not report data for MDD
Broota, A, and Dhir, R. (1990). Efficacy of two relaxation techniques in depression. <i>Journal of Personality and Clinical Studies</i> , 6(1), 83-90.	Does not report data for MDD
Brotto, L. A., Basson, R., and Luria, M. (2008). A mindfulness-based group psychoeducational intervention targeting sexual arousal disorder in women. <i>Journal of Sexual Medicine</i> , 5(7), 1646-1659. doi: 10.1111/j.1743-6109.2008.00850.x	Does not report data for MDD
Brotto, L. A., Heiman, J. R., Goff, B., Greer, B., Lentz, G. M., Swisher, E., Tamimi, H., and Amy Van Blaricom, A.(2008). A psychoeducational intervention for sexual dysfunction in women with gynecologic cancer. <i>Archives of sexual behavior</i> , 37(2), 317-329. doi: 10.1007/s10508-007-9196-x	Does not report data for MDD

Publication	Exclusion Reason
Brown, R. P., and Gerbarg, P. L. (2005). Sudarshan Kriya yogic breathing in the treatment of stress, anxiety, and depression: part I-neurophysiologic model. <i>Journal of Alternative and Complementary Medicine</i> , 11(1), 189-201. doi: 10.1089/acm.2005.11.189	Nonsystematic review
Brown, R. A., Evans, D. M., Miller, I. W., Burgess, E. S., and Mueller, T. I. (1997). Cognitive-behavioral treatment for depression in alcoholism. <i>Journal of Consulting and Clinical Psychology</i> , 65(5), 715-726.	Does not report data for meditation for MDD
Buffart, L. M., van Uffelen, J. G., Riphagen, II, Brug, J., van Mechelen, W., Brown, W. J., and Chinapaw, M. J. (2012). Physical and psychosocial benefits of yoga in cancer patients and survivors, a systematic review and meta-analysis of randomized controlled trials. <i>BMC Cancer</i> , 12, 559. doi: 10.1186/1471-2407-12-559	Systematic review
Burini, D., Farabollini, B., Iacucci, S., Rimatori, C., Riccardi, G., Capecci, M., Provinciali, L., and Ceravolo, M. G. (2006). A randomised controlled cross-over trial of aerobic training versus Qigong in advanced Parkinson's disease. <i>Eura Medicophys</i> , 42(3), 231-238.	Does not report data for MDD
Burns, J. L., Lee, R. M., and Brown, L. J. (2011). The effect of meditation on self-reported measures of stress, anxiety, depression, and perfectionism in a college population. <i>Journal of College Student Psychotherapy</i> , 25(2), 132-144. doi: 10.1080/87568225.2011.556947	Does not report data for MDD
Bussing, A., Michalsen, A., Khalsa, S. B. S., Telles, S., and Sherman, K. J. (2012). Effects of yoga on mental and Physical Health: A Short Summary of Reviews. <i>Evidence-Based Complementary and Alternative Medicine</i> . doi: 10.1155/2012/165410	Nonsystematic review
Butler, L. D., Waelde, L. C., Hastings, T. A., Chen, X. H., Symons, B., Marshall, J., Kaufman, A., Nagy, T. F., Blasey, C. M., Seibert, E. O. and David Spiegel. (2008). Meditation with yoga, group therapy with hypnosis, and psychoeducation for long-term depressed mood: a randomized pilot trial. <i>Journal of Clinical Psychology</i> , 64(7), 806-820. doi: 10.1002/jclp.20496	Does not report data for MDD
Cabral, P., Meyer, H. B., and Ames, D. (2011). Effectiveness of yoga therapy as a complementary treatment for major psychiatric disorders: a meta-analysis. <i>The primary care companion to CNS disorders</i> , 13(4). doi: 10.4088/PCC.10r01068	Systematic review
Capecelatro, M., Brown, A. C., Bond, J., Rosenfeld, A., Kurtz-Nelson, E., Anderson, C., and Britton, W. (2010). Linguistic Markers of Positive Treatment Response to Mindfulness-Based Cognitive Therapy for Depression. <i>International Journal of Behavioral Medicine</i> , 17, 141-141.	Conference proceeding
Carei, T. R., Breuner, C. C., and Fyfe-Johnson, A. (2007). The evaluation of yoga in the treatment of eating disorders. <i>Journal of Adolescent Health</i> , 40(2), S31-32.	Does not report data for MDD
Carei, T. R., Fyfe-Johnson, A. L., Breuner, C. C., and Brown, M. A. (2010). Randomized controlled clinical trial of yoga in the treatment of eating disorders. <i>Journal of Adolescent Health</i> , 46(4), 346-351. doi: 10.1016/j.jadohealth.2009.08.007	Children only
Carlson, K.J., Silva, S.G., Langley, J. Johnson, C. (2013). Mindful-Veteran: The implementation of a brief stress reduction course <i>Complementary Therapies in Clinical Practice</i> , 19:e89-e96	Not RCT
Carlson, L. E., and Garland, S. N. (2005). Impact of mindfulness-based stress reduction (MBSR) on sleep, mood, stress and fatigue symptoms in cancer outpatients. <i>International Journal of Behavioral Medicine</i> , 12(4), 278-285. doi: 10.1207/s15327558ijbm1204_9	Does not report data for MDD

Publication	Exclusion Reason
Cavanagh, K., Strauss, C., Cicconi, F., Griffiths, N., Wyper, A., and Jones, F. (2013). A randomised controlled trial of a brief online mindfulness-based intervention. <i>Behaviour Research and Therapy</i> , 51(9), 573-578. doi: 10.1016/j.brat.2013.06.003	Does not report data for MDD
Chambers, S. K., Smith, D. P., Berry, M., Lepore, S. J., Foley, E., Clutton, S., McDowall, R., Occhipinti, S., Frydenberg, M., and Gardiner, R. A. (2013). A randomised controlled trial of a mindfulness intervention for men with advanced prostate cancer. <i>BMC Cancer</i> , 13, 89. doi: 10.1186/1471-2407-13-89	Does not report data for MDD
Chan, A. S., Wong, Q. Y., Sze, S. L., Kwong, P. P. K., Han, Y. M. Y., and Cheung, M. C. (2012). A Chinese Chan-based mind-body intervention for patients with depression. <i>Journal of Affective Disorders</i> , 142(1-3), 283-289. doi: 10.1016/j.jad.2012.05.018	Not MBCT
Chan, E. S., Koh, D., Teo, Y. C., Hj Tamin, R., Lim, A., and Fredericks, S. (2013). Biochemical and psychometric evaluation of self-healing qigong as a stress reduction tool among first year nursing and midwifery students. <i>Complementary Therapies in Clinical Practice</i> , 19(4), 179-183. doi: 10.1016/j.ctcp.2013.08.001	Does not report data for MDD
Chan, J. S., Ho, R. T., Wang, C. W., Yuen, L. P., Sham, J. S., and Chan, C. L. (2013). Effects of qigong exercise on fatigue, anxiety, and depressive symptoms of patients with chronic fatigue syndrome-like illness: a randomized controlled trial. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 485341. doi: 10.1155/2013/485341	Does not report data for MDD
Chan, W., Immink, M. A., and Hillier, S. (2012). Yoga and exercise for symptoms of depression and anxiety in people with poststroke disability: a randomized, controlled pilot trial. <i>Alternative Therapies In Health And Medicine</i> , 18(3), 34-43.	Does not report data for MDD
Chandwani, K. D., Thornton, B., Perkins, G. H., Arun, B., Raghuram, N. V., Nagendra, H. R., Wei, Q., and Lorenzo Cohen, L. (2010). Yoga improves quality of life and benefit finding in women undergoing radiotherapy for breast cancer. <i>Journal of the Society for Integrative Oncology</i> , 8(2), 43-55.	Does not report data for MDD
Chen, K. M., Chen, M. H., Lin, M. H., Fan, J. T., Lin, H. S., and Li, C. H. (2010). Effects of yoga on sleep quality and depression in elders in assisted living facilities. <i>Journal of Nursing Research</i> , 18(1), 53-61. doi: 10.1097/JNR.0b013e3181ce5189	Does not report data for MDD
Chen, K. W., Berger, C. C., Gandhi, D., Weintraub, E., and Lejuez, C. W. (2013). Adding integrative meditation with ear acupressure to outpatient treatment of cocaine addiction: a randomized controlled pilot study. <i>Journal of Alternative and Complementary Medicine</i> , 19(3), 204-210. doi: 10.1089/acm.2011.0311	Does not report data for MDD
Chen, K. W., Perlman, A., Liao, J. G., Lam, A., Staller, J., and Sigal, L. H. (2008). Effects of external qigong therapy on osteoarthritis of the knee. A randomized controlled trial. <i>Clinical Rheumatology</i> , 27(12), 1497-1505. doi: 10.1007/s10067-008-0955-4	Does not report data for meditation for MDD
Chen, K. M., Chen, M. H., Chao, H. C., Hung, H. M., Lin, H. S., and Li, C. H. (2009). Sleep quality, depression state, and health status of older adults after silver yoga exercises: Cluster randomized trial. <i>International Journal of Nursing Studies</i> , 46(2), 154-163. doi: 10.1016/j.ijnurstu.2008.09.005	Does not report data for MDD
Chen, Y., Yang, X., Wang, L., and Zhang, X. (2013). A randomized controlled trial of the effects of brief mindfulness meditation on anxiety symptoms and systolic blood pressure in Chinese nursing students. <i>Nurse Education Today</i> , 33(10), 1166-1172. doi: 10.1016/j.nedt.2012.11.014	Does not report data for MDD

Publication	Exclusion Reason
Cheng, S. T., Chow, P. K., Yu, E. C., and Chan, A. C. (2012). Leisure activities alleviate depressive symptoms in nursing home residents with very mild or mild dementia. <i>American Journal of Geriatric Psychiatry</i> , 20(10), 904-908. doi: 10.1097/JGP.0b013e3182423988	Does not report data for MDD
Cheon, S. M., Chae, B. K., Sung, H. R., Lee, G. C., and Kim, J. W. (2013). The efficacy of exercise programs for parkinson's disease: Tai Chi versus combined exercise. <i>Journal of Clinical Neurology</i> , 9(4), 237-243. doi: 10.3988/jcn.2013.9.4.237	Does not report data for MDD
Cheung, B. M. Y., J. L. F. Lo, D. Y. T. Fong, M. Y. Chan, S. H. T. Wong, V. C. W. Wong, K. S. L. Lam, C. P. Lau, and J. P. E. Karlberg. (2005). Randomised controlled trial of qigong in the treatment of mild essential hypertension. <i>Journal of human hypertension</i> , 19(9), 697-704. doi: 10.1038/sj.jhh.1001884	Does not report data for MDD
Chhatre, S., Metzger, D. S., Frank, I., Boyer, J., Thompson, E., Nidich, S., Montaner, L. J., and Jayadevappa, R. (2013). Effects of behavioral stress reduction Transcendental Meditation intervention in persons with HIV. <i>AIDS Care</i> , 25(10), 1291-1297. doi: 10.1080/09540121.2013.764396	Does not report data for MDD
Chi, I., Jordan-Marsh, M., Guo, M., Xie, B., and Bai, Z. (2013). Tai Chi and reduction of depressive symptoms for older adults: a meta-analysis of randomized trials. <i>Geriatrics & Gerontology International</i> , 13(1), 3-12. doi: 10.1111/j.1447-0594.2012.00882.x	Systematic review
Chi, I., Jordan-Marsh, M., Guo, M., Xie, B., and Zhang, M. (2008). Tai Chi for depression. <i>Cochrane Database of Systematic Reviews</i> (2).	Study protocol
Chiesa, A., and Serretti, A. (2010a). Mindfulness based cognitive therapy for major depression: a systematic review and meta-analysis. <i>European Psychiatry</i> , 25.	Systematic review
Chiesa, A., and Serretti, A. (2010b). A systematic review of neurobiological and clinical features of mindfulness meditations. <i>Psychological Medicine</i> , 40(8), 1239-1252. doi: 10.1017/s0033291709991747	Systematic review
Chiesa, A., and Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: a systematic review and meta-analysis. <i>Psychiatry Research</i> , 187(3), 441-453. doi: 10.1016/j.psychres.2010.08.011	Systematic review
Chou, K.-L., Lee, P. W. H., Yu, E. C. S., Macfarlane, D., Chen, Y.-H., Chan, S. S. C., and Chi, I. (2008) "Effect of Tai Chi on depressive symptoms amongs Chinese older patients with depressive disorders: A randomized clinical trial," <i>State of the Art in International Research</i> , 52, 146-154.	Does not report data for MDD
Chou, K.-L., Lee, P. W. H., Yu, E. C. S., Macfarlane, D., Chen, Y.-H., Chan, S. S. C., and Chi, I.(2004) "Effect of Tai Chi on depressive symptoms amongs Chinese older patients with depressive disorders: A randomized clinical trial," <i>International Journal of Geriatric Psychology</i> , 19, 1105-1107.	Does not report data for MDD
Chiesa, A., and Serretti, A. (2011). Mindfulness-based interventions for chronic pain: a systematic review of the evidence. <i>Journal of Alternative and Complementary Medicine</i> , 17(1), 83-93. doi: 10.1089/acm.2009.0546	Systematic review
Christman, N. J., and Cain, L. B. (2004). The effects of concrete objective information and relaxation on maintaining usual activity during radiation therapy. <i>Oncology Nursing Forum</i> , 31(2), E39-45. doi: 10.1188/04.onf.e39-e45	Does not report data for MDD
Chu, I. H., and Lin, Y. J. (2013). Effects of yoga on depressive symptoms and cardiac autonomic control in women. <i>Psychophysiology</i> , 50, S101-S101.	Conference proceeding
Coelho, H. F., Canter, P. H., and Ernst, E. (2007). Mindfulness-based cognitive therapy: evaluating current evidence and informing future research. <i>Journal of Consulting and Clinical Psychology</i> , 75(6), 1000-1005. doi: 10.1037/0022-006x.75.6.1000	Systematic review

Publication	Exclusion Reason
Cohen, G. E., and Shamus, E. (2009). Depressed, low self-esteem: what can exercise do for you? <i>Internet Journal of Allied Health Sciences and Practice</i> , 7(2), 5p.	Does not report data for MDD
Cohen, L., Warneke, C., Fouladi, R. T., Rodriguez, M. A., and Chaoul-Reich, A. (2004). Psychological adjustment and sleep quality in a randomized trial of the effects of a Tibetan yoga intervention in patients with lymphoma. <i>Cancer</i> , 100(10), 2253-2260. doi: 10.1002/cncr.20236	Does not report data for MDD
Cole, B. S., Hopkins, C. M., Spiegel, J., Tisak, J., Agarwala, S., and Kirkwood, J. M. (2012). A randomised clinical trial of the effects of spiritually focused meditation for people with metastatic melanoma. <i>Mental Health, Religion and Culture</i> , 15(2), 161-174. doi: 10.1080/13674676.2011.562492	Does not report data for MDD
Collinge, W., Kahn, J., and Soltysik, R. (2012). Promoting reintegration of National Guard veterans and their partners using a self-directed program of integrative therapies: a pilot study. <i>Military Medicine</i> , 177(12), 1477-1485.	Does not report data for MDD
Collins, J. A., and Rice, V. H. (1997). Effects of relaxation intervention in phase II cardiac rehabilitation: replication and extension. <i>Heart Lung</i> , 26(1), 31-44.	Does not report data for MDD
Collip, D., Geschwind, N., Peeters, F., Myin-Germeys, I., van Os, J., and Wichers, M. (2013). Putting a hold on the downward spiral of paranoia in the social world: a randomized controlled trial of mindfulness-based cognitive therapy in individuals with a history of depression. <i>PLoS One</i> , 8(6), e66747. doi: 10.1371/journal.pone.0066747	No relevant outcomes reported
Cote, A., and Daneault, S. (2012). Effect of yoga on patients with cancer: our current understanding. <i>Canadian Family Physician</i> , 58(9), e475-479.	Systematic review
Courbasson, C. M., Nishikawa, Y., and Shapira, L. B. (2011). Mindfulness-action based cognitive behavioral therapy for concurrent binge eating disorder and substance use disorders. <i>Eating disorders</i> , 19(1), 17-33. doi: 10.1080/10640266.2011.533603	Does not report data for MDD
Cox, C. E., Porter, L. S., Buck, P. J., Hoffa, M., Jones, D., Walton, B., Hough, C. L., Greeson, J. M. (2013). Development and Preliminary Evaluation of a Telephone-based Mindfulness Training Intervention for Survivors of Critical Illness. <i>Annals of the American Thoracic Society</i> . doi: 10.1513/AnnalsATS.201308-283OC	Does not report data for MDD
Craft, L. L., VanIterson, E. H., Helenowski, I. B., Rademaker, A. W., and Courneya, K. S. (2012). Exercise effects on depressive symptoms in cancer survivors: a systematic review and meta-analysis. <i>Cancer Epidemiology Biomarkers and Prevention</i> , 21(1), 3-19. doi: 10.1158/1055-9965.epi-11-0634	Systematic review
Cramer, H., Lange, S., Klose, P., Paul, A., and Dobos, G. (2012). Yoga for breast cancer patients and survivors: a systematic review and meta-analysis. <i>BMC Cancer</i> , 12, 412. doi: 10.1186/1471-2407-12-412	Systematic review
Cramer, H., Lauche, R., Langhorst, J., and Dobos, G. (2013). Yoga for depression: a systematic review and meta-analysis. <i>Depression and Anxiety</i> , 30(11), 1068-1083. doi: 10.1002/da.22166	Systematic review
Cramer, H., Lauche, R., Paul, A., and Dobos, G. (2012). Mindfulness-based stress reduction for breast cancer- A systematic review and meta-analysis. <i>Current Oncology</i> , 19(5), e343-e352.	Systematic review
Culos-Reed, S. N., Carlson, L. E., Daroux, L. M., and Hatley-Aldous, S. (2006). A pilot study of yoga for breast cancer survivors: physical and psychological benefits. <i>Psychooncology</i> , 15(10), 891-897. doi: 10.1002/pon.1021	Does not report data for MDD

Publication	Exclusion Reason
Curtis, K., Osadchuk, A., and Katz, J. (2011). An eight-week yoga intervention is associated with improvements in pain, psychological functioning and mindfulness, and changes in cortisol levels in women with fibromyalgia. <i>Journal of Pain Research</i> , 4, 189-201. doi: 10.2147/jpr.s22761	Does not report data for MDD
Cusens, B., Duggan, G. B., Thorne, K., and Burch, V. (2010). Evaluation of the breathworks mindfulness-based pain management programme: effects on well-being and multiple measures of mindfulness. <i>Clinical Psychology & Psychotherapy</i> , 17(1), 63-78. doi: 10.1002/cpp.653	Does not report data for MDD
D'Silva, S., Poscablo, C., Habousha, R., Kogan, M., and Kligler, B. (2012). Mind-body medicine therapies for a range of depression severity: a systematic review. <i>Psychosomatics</i> , 53(5), 407-423. doi: 10.1016/j.psych.2012.04.006	Systematic review
da Silva, T. L., Ravindran, L. N., and Ravindran, A. V. (2009). Yoga in the treatment of mood and anxiety disorders: A review. <i>Asian Journal of Psychiatry</i> , 2(1), 6-16. doi: 10.1016/j.ajp.2008.12.002	Systematic review
Danhauer, S. C., Mihalko, S. L., Russell, G. B., Campbell, C. R., Felder, L., Daley, K., and Levine, E. A. (2009). Restorative yoga for women with breast cancer: findings from a randomized pilot study. <i>Psychooncology</i> , 18(4), 360-368. doi: 10.1002/pon.1503	Does not report data for MDD
Danhauer, S. C., Tooze, J. A., Farmer, D. F., Campbell, C. R., McQuellon, R. P., Barrett, R., and Miller, B. E. (2008). Restorative yoga for women with ovarian or breast cancer: findings from a pilot study. <i>Journal of the Society for Integrative Oncology</i> , 6(2), 47-58.	Does not report data for MDD
Danucalov, M. A. D., Kozasa, E. H., Ribas, K. T., Galduroz, J. C. F., Garcia, M. C., Verreschi, I. T. N., Oliveira, K.C., de Oliveira, L. R., and Leite, J. R.. (2013). A yoga and compassion meditation program reduces stress in familial caregivers of Alzheimer's disease patients. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 513149. doi: 10.1155/2013/513149	Does not report data for MDD
Davis, L., and Kurzban, S. (2012). Mindfulness-based treatment for people with severe mental illness: A literature review. <i>American Journal of Psychiatric Rehabilitation</i> , 15(2), 202-232.	Nonsystematic review
Day, P. O., and Horton-Deutsch, S. (2004). Using mindfulness-based therapeutic interventions in psychiatric nursing practice-part I: Description and empirical support for mindfulness-based interventions. <i>Archives of Psychiatric Nursing</i> , 18(5), 164-169. doi: 10.1016/j.apnu.2004.07.003	Nonsystematic review
De Raedt, R., Baert, S., Demeyer, I., Goeleven, E., Raes, A., Visser, A., . . . Speckens, A. (2012). Changes in attentional processing of emotional information following mindfulness-based cognitive therapy in people with a history of depression: towards an open attention for all emotional experiences. <i>Cognitive Therapy and Research</i> , 36(6), 612-620. doi: 10.1007/s10608-011-9411-x	Not RCT
Deatherage, Gary. (1975). The clinical use of 'mindfulness' meditation techniques in short-term psychotherapy. <i>Journal of Transpersonal Psychology</i> , 7(2), 133-143.	Case report
DeBerry, S. (1982). The effects of meditation-relaxation on anxiety and depression in a geriatric population. <i>Psychotherapy</i> , 19(4), 512-521.	Does not report data for MDD
DeBerry, S., Davis, S., and Reinhard, K. E. (1989). A comparison of meditation-relaxation and cognitive/behavioral techniques for reducing anxiety and depression in a geriatric population. <i>Journal of geriatric psychiatry</i> , 22(2), 231-247.	Does not report data for MDD

Publication	Exclusion Reason
Degi, C. L., and Szilagy, T. (2013). Mindfulness-based stress reduction intervention in Romanian breast cancer inpatients. <i>Cognition, Brain, Behavior: An Interdisciplinary Journal</i> , 17(2), 135-148.	Does not report data for MDD
Delmonte, M. M. (1984). Psychometric scores and meditation practice: A literature review. <i>Personality and Individual Differences</i> , 5(5), 559-563. doi: 10.1016/0191-8869(84)90030-8	Nonsystematic review
Delui, M. H., Yari, M., Khouyinezhad, G., Amini, M. and Bayazi, M. H. (2013) "Comparison of cardiac rehabilitation programs combined with relaxation and meditation techniques on reduction of depression and anxiety of cardiovascular patients," <i>Open Cardiovasc Med J</i> , 7, 99-103.	Does not report data for MDD
Dempsey, C., M. Chesney, L. Lao, P. Vegella, T. Magyari, M. B. Robertson, B. Berman, and E. Kimbrough, "Acupuncture and Mindfulness-Based Stress Reduction among Female Child Abuse Survivors: A Randomized Waitlist-Controlled Pilot Study," <i>Journal of Alternative and Complementary Medicine</i> , Vol. 20, No. 5, 2014, p. A87. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L71474828	Abstract only
Dhananjai, S., Sadashiv, Tiwari, S., Dutt, K., and Kumar, R. (2013). Reducing psychological distress and obesity through Yoga practice. <i>International Journal of Yoga (IJoY)</i> , 6(1), 66-70. doi: 10.4103/0973-6131.105949	Does not report data for MDD
Dimidjian, S., and Davis, K. J. (2009). Newer variations of cognitive-behavioral therapy: behavioral activation and mindfulness-based cognitive therapy. <i>Current Psychiatry Reports</i> , 11(6), 453-458.	Nonsystematic review
Dindo, L., A. Recober, J. Marchman, M. W. O' Hara, and C. Turvey, "One-Day Behavioral Intervention in Depressed Migraine Patients: Effects on Headache," <i>Headache</i> , Vol. 54, No. 3, Mar, 2014, pp. 528-538. <Go to ISI>://WOS:000332156900011 http://onlinelibrary.wiley.com/store/10.1111/head.12258/asset/head12258.pdf?v=1&t=i7gk12kx&s=864a162bcc9c818ef55277aa4a0e80872a262da7	Not RCT
Dobkin, P. L., and Zhao, Q. (2011). Increased mindfulness--the active component of the mindfulness-based stress reduction program? <i>Complementary Therapies in Clinical Practice</i> , 17(1), 22-27. doi: 10.1016/j.ctcp.2010.03.002	Does not report data for MDD
Donesky, D., Melendez, M., Nguyen, H. Q., and Carrieri-Kohlman, V. (2012). A responder analysis of the effects of yoga for individuals with COPD: who benefits and how? <i>International Journal of Yoga (IJoY) Therap</i> (22), 23-36.	Does not report data for MDD
Duncan, L. G., and Bardacke, N. (2010). Mindfulness-Based Childbirth and Parenting Education: Promoting Family Mindfulness During the Perinatal Period. <i>Journal of Child and Family Studies</i> , 19(2), 190-202. doi: 10.1007/s10826-009-9313-7	Does not report data for MDD
Duncan, L. G., Moskowitz, J. T., Neilands, T. B., Dilworth, S. E., Hecht, F. M., and Johnson, M. O. (2012). Mindfulness-based stress reduction for HIV treatment side effects: a randomized, wait-list controlled trial. <i>Journal of Pain and Symptom Management</i> , 43(2), 161-171. doi: 10.1016/j.jpainsymman.2011.04.007	Does not report data for MDD
Dunn, C., Hanieh, E., Roberts, R., and Powrie, R. (2012). Mindful pregnancy and childbirth: effects of a mindfulness-based intervention on women's psychological distress and well-being in the perinatal period. <i>Archives of Women's Mental Health</i> , 15(2), 139-143. doi: 10.1007/s00737-012-0264-4	Does not report data for MDD
Edenfield, T. M., and Saeed, S. A. (2012). An update on mindfulness meditation as a self-help treatment for anxiety and depression. <i>Psychology research and behavior management</i> , 5, 131-141. doi: 10.2147/prbm.s34937	Nonsystematic review

Publication	Exclusion Reason
Eisendrath, S. J., Delucchi, K., Bitner, R. Fenimore, P., Smit, M. and McLane, M.. (2008). Mindfulness-based cognitive therapy for treatment-resistant depression: a pilot study. <i>Psychotherapy and Psychosomatics</i> ;77:319–320.	Not RCT
Eisendrath, S. J., E. P. Gillung, K. L. Delucchi, M. Chartier, D. H. Mathalon, J. C. Sullivan, Z. V. Segal, and M. D. Feldman, "Mindfulness-Based Cognitive Therapy (MBCT) Versus the Health-Enhancement Program (Hep) for Adults with Treatment-Resistant Depression: A Randomized Control Trial Study Protocol," <i>BMC Complement Altern Med</i> , Vol. 14, 2014, p. 95. http://www.biomedcentral.com/content/pdf/1472-6882-14-95.pdf	Study protocol
Elavsky, S., and McAuley, E. (2007). Lack of perceived sleep improvement after 4-month structured exercise programs. <i>Menopause</i> , 14(3 Pt 1), 535-540. doi: 10.1097/01.gme.0000243568.70946.d4	Does not report data for MDD
Eller, L. S. (1995). Effects of two cognitive-behavioral interventions on immunity and symptoms in persons with HIV. <i>Annals of Behavioral Medicine</i> , 17(4), 339-348.	Does not report data for MDD
Emani, S., and Binkley, P. F. (2010). Mind-body medicine in chronic heart failure: A translational science challenge. <i>Circulation: Heart Failure</i> , 3(6), 715-725.	Nonsystematic review
Ernst, E., and Lee, M. S. (2010). How effective is yoga? A concise overview of systematic reviews. <i>Focus on Alternative and Complementary Therapies</i> , 15(4), 274-279.	Systematic review
Ernst, S., Welke, J., Heintze, C., Gabriel, R., Zollner, A., Kiehne, S., . . . Esch, T. (2008). Effects of mindfulness-based stress reduction on quality of life in nursing home residents: a feasibility study. <i>Forsch Komplementmed</i> , 15(2), 74-81. doi: 10.1159/000121479	Does not report data for MDD
Evans, S. (2010). Review: mindfulness-based therapies effective for anxiety and depression. <i>Evidence-Based Mental Health - BMJ Journals</i> , 13(4), 116. doi: 10.1136/ebmh.13.4.116	Background or commentary
Evans, S., Moieni, M., Lung, K., Tsao, J., Sternlieb, B., Taylor, M., and Zeltzer, L. (2013). Impact of iyengar yoga on quality of life in young women with rheumatoid arthritis. <i>Clinical Journal of Pain</i> , 29(11), 988-997. doi: 10.1097/AJP.0b013e31827da381	Does not report data for MDD
Eyre, H. A., and Baune, B. T. (2013). Assessing for unique immunomodulatory and neuroplastic profiles of physical activity subtypes: A focus on psychiatric disorders. <i>Brain, Behavior, and Immunity</i> . doi: 10.1016/j.bbi.2013.10.026	Systematic review
Fals-Stewart, W., Marks, A. P., and Schafer, J. (1993). A comparison of behavioral group therapy and individual behavior therapy in treating obsessive-compulsive disorder. <i>Journal of Nervous and Mental Disease</i> , 181(3), 189-193.	Does not report data for MDD
Fan, J. T., and Chen, K. M. (2011). Using silver yoga exercises to promote physical and mental health of elders with dementia in long-term care facilities. <i>International Psychogeriatrics</i> , 23(8), 1222-1230. doi: 10.1017/s1041610211000287	Does not report data for MDD
Farb, N. A., Anderson, A. K., Mayberg, H., Bean, J., McKeon, D., and Segal, Z. V. (2010). Minding one's emotions: mindfulness training alters the neural expression of sadness. <i>Emotion</i> , 10(1), 25-33. doi: 10.1037/a0017151	Does not report data for meditation for MDD
Faucher, M. A. (2013). Mindfulness yoga improves scores on depression scales and fosters maternal-fetal attachment. <i>Journal of Midwifery & Women's Health</i> , 58(1), 111-112. doi: 10.1111/j.1542-2011.2012.00264_2.x	Does not report data for MDD
Feldman, M. D., E. P. Gillung, K. Delucchi, and S. J. Eisendrath, "Mindfulness Based Cognitive Therapy Versus a Health Enhancement Program for Treatment Resistant Depression: A Randomized Controlled Trial," <i>Journal of General Internal Medicine</i> , Vol. 29, Apr, 2014, pp. S150-S151. <Go to ISI>://WOS:000340996200351	Abstract only

Publication	Exclusion Reason
Felteau, M. M., and R. B. Gainer, "Mindfulness-Based Cognitive Therapy for Tbi Reduces Symptoms of Depression: Results from a Randomized Controlled Trial," <i>Archives of Physical Medicine and Rehabilitation</i> , Vol. 95, No. 10, 2014, p. e11. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L71665559	Abstract only
Ferguson, P., and Gowan, J. (1976). TM: Some preliminary findings. <i>Journal of Humanistic Psychology</i> , 16(3), 51-60. doi: 10.1177/002216787601600307	Does not report data for MDD
Fergusson, L. C., Bonshek, A. J., and Boudigues, J. M. (1995). Personality and health characteristics of Cambodian undergraduates: a case for student development. <i>Journal of Instructional Psychology</i> , 22(4), 308-319.	Does not report data for MDD
Field, T. (2008). Pregnancy and labor alternative therapy research. <i>Alternative Therapies In Health And Medicine</i> , 14(5), 28-34.	Nonsystematic review
Field, T., Diego, M.A., Hernandez-Reif, M., Schanberg, S. and Kuhn, C. (2004). Massage therapy effects on depressed pregnant women. <i>Journal of Psychosom Obstet Gynecol</i> , 25:115–122.	Not MBCT
A. Finucane and S. W. Mercer. (2006) An exploratory mixed methods study of the acceptability and effectiveness of Mindfulness-Based Cognitive Therapy for patients with active depression and anxiety in primary care. <i>BMC Psychiatry</i> , 6:14.	Not RCT
Fiore, R., R. Nelson, and E. Tosti, "The Use of Yoga, Meditation, Mantram, and Mindfulness to Enhance Coping in Veterans with PTSD," <i>Therapeutic Recreation Journal</i> , Vol. 48, No. 4, 2014, pp. 337-340. http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2012786871&site=ehost-live	Review
Fish, J. A., Ettridge, K., Sharplin, G. R., Hancock, B., and Knott, V. E. (2013). Mindfulness-based Cancer Stress Management: impact of a mindfulness-based programme on psychological distress and quality of life. <i>European Journal of Cancer Care (Engl)</i> . doi: 10.1111/ecc.12136	Does not report data for MDD
Fjorback, L. O. (2012). Mindfulness and bodily distress. <i>Danish Medical Journal</i> , 59(11), B4547.	Does not report data for MDD
Fjorback, L. O., Arendt, M., Ornbol, E., Fink, P., and Walach, H. (2011). Mindfulness-based stress reduction and mindfulness-based cognitive therapy: a systematic review of randomized controlled trials. <i>Acta Psychiatrica Scandinavica</i> , 124(2), 102-119. doi: 10.1111/j.1600-0447.2011.01704.x	Systematic review
Fjorback, L. O., and Walach, H. (2012). Meditation based therapies-a systematic review and some critical observations. <i>Religions</i> , 3(1), 1-18. doi: 10.3390/rel3010001	Systematic review
Fledderus, M., Bohlmeijer, E. T., Smit, F., and Westerhof, G. J. (2010). Mental health promotion as a new goal in public mental health care: a randomized controlled trial of an intervention enhancing psychological flexibility. <i>American Journal of Public Health</i> , 100(12), 2372-2378. doi: 10.2105/ajph.2010.196196	Does not report data for MDD
Foley, E., Baillie, A., Huxter, M., Price, M., and Sinclair, E. (2010). Mindfulness-based cognitive therapy for individuals whose lives have been affected by cancer: a randomized controlled trial. <i>Journal of Consulting and Clinical Psychology</i> , 78(1), 72-79. doi: 10.1037/a0017566	Does not report data for MDD

Publication	Exclusion Reason
Forbes, D., Thiessen, E. J., Blake, C. M., Forbes, S. C., and Forbes, S. (2013). Exercise programs for people with dementia. <i>Cochrane Database of Systematic Reviews (CDSR)</i> , 12, CD006489. doi: 10.1002/14651858.CD006489.pub3	Systematic review
Forfyflow, Andrea L. (2011). Integrating yoga with psychotherapy: A complementary treatment for anxiety and depression. <i>Canadian Journal of Counselling and Psychotherapy</i> , 45(2), 132-150.	Nonsystematic review
Fortney, L., Luchterhand, C., Zakletskaia, L., Zgierska, A., and Rakel, D. (2013). Abbreviated mindfulness intervention for job satisfaction, quality of life, and compassion in primary care clinicians: a pilot study. <i>Annals of Family Medicine</i> , 11(5), 412-420. doi: 10.1370/afm.1511	Does not report data for MDD
Foulk, M. A., Ingersoll-Dayton, B., Kavanagh, J., Robinson, E. A., and Kales, H. (2012). Adapting Mindfulness-Based Cognitive Therapy (MBCT) for Depression in Later Life: Modifications and Pre/Post Outcomes. <i>Gerontologist</i> , 52, 429-429.	Conference proceeding
Foureux, M., Besley, K., Burton, G., Yu, N., and Crisp, J. (2013). Enhancing the resilience of nurses and midwives: pilot of a mindfulness-based program for increased health, sense of coherence and decreased depression, anxiety and stress. <i>Contemporary Nurse</i> , 45(1), 114-125. doi: 10.5172/conu.2013.45.1.114	Does not report data for MDD
Fox, S. D., Flynn, E., and Allen, R. H. (2011). Mindfulness meditation for women with chronic pelvic pain: a pilot study. <i>Journal of Reproductive Medicine</i> , 56(3-4), 158-162.	Does not report data for MDD
Franco, C., Manas, I., Cangas, A. J., Moreno, E., and Gallego, J. (2010). Reducing teachers' psychological distress through a mindfulness training program. <i>Spanish Journal of Psychology</i> , 13(2), 655-666.	Does not report data for MDD
Fredrickson, B. L., Cohn, M. A., Coffey, K. A., Pek, J., and Finkel, S. M. (2008). Open hearts build lives: positive emotions, induced through loving-kindness meditation, build consequential personal resources. <i>Journal of Personality and Social Psychology</i> , 95(5), 1045-1062. doi: 10.1037/a0013262	Does not report data for MDD
Freeman, M. P., Fava, M., Lake, J., Trivedi, M. H., Wisner, K. L., and Mischoulon, D. (2010). Complementary and alternative medicine in major depressive disorder: the American Psychiatric Association Task Force report. <i>Journal of Clinical Psychiatry</i> , 71(6), 669-681. doi: 10.4088/JCP.10cs05959blu	Systematic review
Frenkel, M., and Shah, V. (2008). Complementary medicine can benefit palliative care -- part 2. <i>European Journal of Palliative Care</i> , 15(6), 288-293.	Nonsystematic review
Friedberg, M. W. (2009). Mindfulness-based cognitive therapy: a potential new alternative to medication for recurrent depression. <i>Journal of Clinical Outcomes Management</i> , 16(2), 63-64.	Background
Galante, J., I. Galante, M. J. Bekkers, and J. Gallacher, "Effect of Kindness-Based Meditation on Health and Well-Being: A Systematic Review and Meta-Analysis," <i>J Consult Clin Psychol</i> , Vol. 82, No. 6, Dec, 2014, pp. 1101-1114. http://psycnet.apa.org/index.cfm?fa=search.displayrecord&uid=2014-26574-001	Systematic review
Galante, J., Iribarren, S. J., and Pearce, P. F. (2013). Effects of mindfulness-based cognitive therapy on mental disorders: a systematic review and meta-analysis of randomised controlled trials. <i>Journal of Research in Nursing</i> , 18(2), 133-155. doi: 10.1177/1744987112466087	Systematic review
Galantino, M. L., Bzdewka, T. M., Eissler-Russo, J. L., Holbrook, M. L., Mogck, E. P., Geigle, P., and Farrar, J. T. (2004). The impact of modified Hatha yoga on chronic low back pain: a pilot study. <i>Alternative Therapies In Health And Medicine</i> , 10(2), 56-59.	Does not report data for MDD

Publication	Exclusion Reason
Galantino, M. L., Cannon, N., Hoelker, T., Iannaco, J., and Quinn, L. (2007). Potential benefits of walking and yoga on perceived levels of cognitive decline and persistent fatigue in women with breast cancer. <i>Rehabilitation Oncology</i> , 25(3), 3-16.	Does not report data for meditation for MDD
Galhardo, A., Cunha, M., and Pinto-Gouveia, J. (2013a). Mindfulness-based program for infertility: efficacy study. <i>Fertility and Sterility</i> , 100(4), 1059-1067.	Does not report data for MDD
Gallegos, A. M., Hoerger, M., Talbot, N. L., Moynihan, J. A., and Duberstein, P. R. (2013). Emotional benefits of mindfulness-based stress reduction in older adults: the moderating roles of age and depressive symptom severity. <i>Aging & Mental Health</i> , 17(7), 823-829. doi: 10.1080/13607863.2013.799118	Does not report data for MDD
Gangadhar, B. N., Naveen, G. H., Rao, M. G., Thirthalli, J., and Varambally, S. (2013). Positive antidepressant effects of generic yoga in depressive out-patients: A comparative study. <i>Indian Journal of Psychiatry</i> , 55(Suppl 3), S369-373. doi: 10.4103/0019-5545.116312	Not RCT
Ganpat, T. S., and Nagendra, H. R. (2011). Integrated yoga therapy for improving mental health in managers. <i>Industrial Psychiatry Journal</i> , 20(1), 45-48. doi: 10.4103/0972-6748.98415	Does not report data for MDD
Garland, E. L., N. Geschwind, F. Peeters, and M. Wichers, "Mindfulness Training Promotes Upward Spirals of Positive Affect and Cognition: Multilevel and Autoregressive Latent Trajectory Modeling Analyses," <i>Front Psychol</i> , Vol. 6, 2015, p. 15. http://journal.frontiersin.org/article/10.3389/fpsyg.2015.00015/pdf	Does not report relevant outcome data
Garland, S. N., Tamagawa, R., Todd, S. C., Specia, M., and Carlson, L. E. (2013). Increased mindfulness is related to improved stress and mood following participation in a mindfulness-based stress reduction program in individuals with cancer. <i>Integrative Cancer Therapies</i> , 12(1), 31-40. doi: 10.1177/1534735412442370	Does not report data for MDD
Gayner, B., Esplen, M. J., DeRoche, P., Wong, J., Bishop, S., Kavanagh, L., and Butler, K. (2012). A randomized controlled trial of mindfulness-based stress reduction to manage affective symptoms and improve quality of life in gay men living with HIV. <i>Journal of Behavioral Medicine</i> , 35(3), 272-285. doi: 10.1007/s10865-011-9350-8	Does not report data for MDD
Gerard, S., Smith, B. H., and Simpson, J. A. (2003). A randomized controlled trial of spiritual healing in restricted neck movement. <i>Journal of Alternative and Complementary Medicine</i> , 9(4), 467-477. doi: 10.1089/107555303322284758	Does not report data for MDD
Gerbarg, P. L., Wallace, G., and Brown, R. P. (2011). Mass disasters and mind-body solutions: evidence and field insights. <i>International Journal of Yoga (IJoY) Therap</i> (21), 97-107.	Nonsystematic review
Geschwind, N., Peeters, F., Drukker, M., van Os, J., and Wichers, M. (2011). Mindfulness training increases momentary positive emotions and reward experience in adults vulnerable to depression: a randomized controlled trial. <i>Journal of Consulting and Clinical Psychology</i> , 79(5), 618-628. doi: 10.1037/a0024595	Does not report data for MDD
Gex-Fabry, M., Jermann, F., Kosel, M., Rossier, M. F., Van der Linden, M., Bertschy, G., Bondolfi, G., Aubry, J. M. (2012). Salivary cortisol profiles in patients remitted from recurrent depression: one-year follow-up of a mindfulness-based cognitive therapy trial. <i>Journal of psychiatric research</i> , 46(1), 80-86. doi: 10.1016/j.jpsychires.2011.09.011	Does not report relevant outcome data
Gill, A., Womack, R., and Safranek, S. (2010). Clinical Inquiries: Does exercise alleviate symptoms of depression? <i>Journal of Family Practice</i> , 59(9), 530-531.	Nonsystematic review

Publication	Exclusion Reason
Gold, E., Smith, A., Hopper, I., Herne, D., Tansey, G., and Hulland, C. (2010). Mindfulness-Based Stress Reduction (MBSR) for primary school teachers. <i>Journal of Child and Family Studies</i> , 19(2), 184-189. doi: 10.1007/s10826-009-9344-0	Does not report data for MDD
Goldmeier, D., and Mears, A. J. (2010). Meditation: A review of its use in western medicine and, in particular, its role in the management of sexual dysfunction. <i>Current Psychiatry Reviews</i> , 6(1), 11-14.	Nonsystematic review
Gonzalez-Garcia, M., Ferrer, M. J., Borrás, X., Muñoz-Moreno, J. A., Miranda, C., Puig, J., Perez-Alvarez, N., Soler, J., Feliu-Soler, A., and Carmina R. Fumaz, C. R. (2013). Effectiveness of mindfulness-based cognitive therapy on the quality of life, emotional status, and CD4 cell count of patients aging with HIV infection. <i>AIDS and Behavior</i> . doi: 10.1007/s10461-013-0612-z	Does not report data for MDD
Gorczyński, P., and Faulkner, G. (2010). Exercise therapy for schizophrenia. <i>Cochrane Database of Systematic Reviews (CDSR)</i> (5), CD004412. doi: 10.1002/14651858.CD004412.pub2	Systematic review
Green, S. M., and Bieling, P. J. (2012). Expanding the Scope of Mindfulness-Based Cognitive Therapy: Evidence for Effectiveness in a Heterogeneous Psychiatric Sample. <i>Cognitive and Behavioral Practice</i> , 19(1), 174-180.	Does not report data for MDD
Greeson, J. M. (2009). Mindfulness research update: 2008. <i>Complementary Health Practice Review</i> , 14(1), 10-18.	Systematic review
Groessler, E. J., Weingart, K. R., Aschbacher, K., Pada, L., and Baxi, S. (2008). Yoga for veterans with chronic low-back pain. <i>Journal of Alternative and Complementary Medicine</i> , 14(9), 1123-1129. doi: 10.1089/acm.2008.0020	Does not report data for MDD
Groessler, E. J., Weingart, K. R., Johnson, N., and Baxi, S. (2012). The benefits of yoga for women veterans with chronic low back pain. <i>Journal of Alternative and Complementary Medicine</i> , 18(9), 832-838. doi: 10.1089/acm.2010.0657	Does not report data for MDD
Gross, C. R., Kreitzer, M. J., Reilly-Spong, M., Wall, M., Winbush, N. Y., Patterson, R., Mahowald, M., Cramer-Bornemann, M. (2011). Mindfulness-based stress reduction versus pharmacotherapy for chronic primary insomnia: A randomized controlled clinical trial. <i>Explore: The Journal of Science and Healing</i> , 7(2), 76-87.	Does not report data for MDD
Gross, C. R., Kreitzer, M. J., Russas, V., Treesak, C., Frazier, P. A., and Hertz, M. I. (2004). Mindfulness meditation to reduce symptoms after organ transplant: a pilot study. <i>Advances in Mind-Body Medicine</i> , 20(2), 20-29.	Does not report data for MDD
Gross, C. R., Kreitzer, M. J., Thomas, W., Reilly-Spong, M., Cramer-Bornemann, M., Nyman, J. A., Frazier, P. and Ibrahim, H. N. (2010). Mindfulness-based stress reduction for solid organ transplant recipients: a randomized controlled trial. <i>Alternative Therapies In Health And Medicine</i> , 16(5), 30-38.	Does not report data for MDD
Grossman, P., Kappos, L., Gensicke, H., D'Souza, M., Mohr, D. C., Penner, I. K., and Steiner, C. (2010). MS quality of life, depression, and fatigue improve after mindfulness training: a randomized trial. <i>Neurology</i> , 75(13), 1141-1149. doi: 10.1212/WNL.0b013e3181f4d80d	Does not report data for MDD
Grossman, P., Niemann, L., Schmidt, S., and Walach, H. (2004). Mindfulness-based stress reduction and health benefits. A meta-analysis. <i>Journal of Psychosomatic Research</i> , 57(1), 35-43. doi: 10.1016/s0022-3999(03)00573-7	Systematic review

Publication	Exclusion Reason
Grossman, P., Tiefenthaler-Gilmer, U., Raysz, A., and Kesper, U. (2007). Mindfulness training as an intervention for fibromyalgia: evidence of postintervention and 3-year follow-up benefits in well-being. <i>Psychotherapy and psychosomatics</i> , 76(4), 226-233. doi: 10.1159/000101501	Does not report data for MDD
Grover, P., Varma, V. K., Verma, S. K., and Pershad, D. (1987). Relationship between the patient's attitude towards yoga and the treatment outcome. <i>Indian Journal of Psychiatry</i> , 29(3), 253-258.	Does not report data for MDD
Guarneri, E., Horrigan, B. J., and Pechura, C. M. (2010). The Efficacy and Cost Effectiveness of Integrative Medicine: A Review of the Medical and Corporate Literature. <i>Explore: The Journal of Science and Healing</i> , 6(5), 308-312.	Nonsystematic review
Gupta, P. K., Kumar, M., Kumari, R., and Deo, J. M. (2010). Anuloma-Viloma Pranayama and anxiety and depression among the aged. <i>Journal of the Indian Academy of Applied Psychology</i> , 36(1), 159-164.	Does not report data for MDD
Gyllensten, A. L., Ekdahl, C., and Hansson, L. (2009). Long-term effectiveness of basic body awareness therapy in psychiatric outpatient care. A randomized controlled study. <i>Advances in Physiotherapy</i> , 11(1), 2-12.	Does not report data for MDD
Haag, S., Senf, W., Tagay, S., Langkafel, M., Braun-Lang, U., Pietsch, A., Heuft, G., Talley, N. J., and Holtmann, G. (2007). Is there a benefit from intensified medical and psychological interventions in patients with functional dyspepsia not responding to conventional therapy? <i>Alimentary Pharmacology & Therapeutics</i> , 25(8), 973-986. doi: 10.1111/j.1365-2036.2007.03277.x	Does not report data for MDD
Hamilton, K. E., Wershler, J. L., Macrodimitris, S. D., Backs-Dermott, B. J., Ching, L. E., and Mothersill, K. J. (2012). Exploring the effectiveness of a mixed-diagnosis group cognitive behavioral therapy intervention across diverse populations. <i>Cognitive and Behavioral Practice</i> , 19(3), 472-482. doi: 10.1016/j.cbpra.2011.12.002	Does not report data for MDD
Harner, H., Hanlon, A. L., and Garfinkel, M. (2010). Effect of Iyengar yoga on mental health of incarcerated women: a feasibility study. <i>Nursing Research</i> , 59(6), 389-399. doi: 10.1097/NNR.0b013e3181f2e6ff	Does not report data for MDD
Hartmann, M., Kopf, S., Kircher, C., Faude-Lang, V., Djuric, Z., Augstein, F., Friederich, H. C., Kieser, M., Bierhaus, A., Humpert, P. M., Herzog, W., and Nawroth, P. P. (2012). Sustained effects of a mindfulness-based stress-reduction intervention in type 2 diabetic patients: design and first results of a randomized controlled trial (the Heidelberger Diabetes and Stress-study). <i>Diabetes Care</i> , 35(5), 945-947. doi: 10.2337/dc11-1343	Does not report data for MDD
Harvard Medical School. (2009). Yoga for anxiety and depression. Studies suggest that this practice modulates the stress response. <i>Harvard Mental Health Letter</i> 25(10), 4-5.	Nonsystematic review
Hassed, C., de Lisle, S., Sullivan, G., and Pier, C. (2009). Enhancing the health of medical students: outcomes of an integrated mindfulness and lifestyle program. <i>Advances in Health Sciences Education</i> , 14(3), 387-398. doi: 10.1007/s10459-008-9125-3	Does not report data for MDD
Hawley, L. L., Schwartz, D., Bieling, P. J., Irving, J., Corcoran, K., Farb, N. A. S., Anderson, A. K., and Zindel V. Segal, Z. V. (2013). Mindfulness practice, rumination and clinical outcome in mindfulness-based treatment. <i>Cognitive Therapy and Research</i> . doi: 10.1007/s10608-013-9586-4	Does not report data for MDD
Hayes-Skelton, S. A., Roemer, L., and Orsillo, S. M. (2013). A randomized clinical trial comparing an acceptance-based behavior therapy to applied relaxation for generalized anxiety disorder. <i>Journal of Consulting and Clinical Psychology</i> , 81(5), 761-773. doi: 10.1037/a0032871	Does not report data for MDD

Publication	Exclusion Reason
Heeren, A., Van Broeck, N., and Philippot, P. (2009). The effects of mindfulness on executive processes and autobiographical memory specificity. <i>Behaviour Research and Therapy</i> , 47(5), 403-409. doi: 10.1016/j.brat.2009.01.017	Does not report data for MDD
Heeren, A., and Philippot, P. (2011). Changes in ruminative thinking mediate the clinical benefits of mindfulness: preliminary findings. <i>Mindfulness</i> , 2(1), 8-13.	Does not report data for MDD
Hempel, S., S. L. Taylor, N. J. Marshall, I. M. Miake-Lye, J. M. Beroes, R. Shanman, M. R. Solloway, and P. G. Shekelle, "VA Evidence-Based Synthesis Program Reports," <i>Evidence Map of Mindfulness</i> , Washington (DC): Department of Veterans Affairs (US), 2014.	Not RCT
Hempel, S., S. L. Taylor, M. R. Solloway, I. M. Miake-Lye, J. M. Beroes, R. Shanman, and P. G. Shekelle, "VA Evidence-Based Synthesis Program Reports," <i>Evidence Map of Tai Chi</i> , Washington (DC): Department of Veterans Affairs (US), 2014.	Not RCT
Henderson, V. P., Clemow, L., Massion, A. O., Hurley, T. G., Druker, S., and Hebert, J. R. (2012). The effects of mindfulness-based stress reduction on psychosocial outcomes and quality of life in early-stage breast cancer patients: a randomized trial. <i>Breast Cancer Research and Treatment</i> , 131(1), 99-109. doi: 10.1007/s10549-011-1738-1	Does not report data for MDD
Henderson, V. P., Massion, A. O., Clemow, L., Hurley, T. G., Druker, S., and Hebert, J. R. (2013). A randomized controlled trial of mindfulness-based stress reduction for women with early-stage breast cancer receiving radiotherapy. <i>Integrative Cancer Therapies</i> , 12(5), 404-413. doi: 10.1177/1534735412473640	Does not report data for MDD
Hernandez-Reif, M., Field, T., Krasnegor, J., and Theakston, H. (2001). Lower back pain is reduced and range of motion increased after massage therapy. <i>International Journal of Neuroscience</i> , 106(3-4), 131-145.	Does not report data for MDD
Hernandez-Reif, M., Field, T., Krasnegor, J., Theakston, H., Hossain, Z., and Burman, I. (2000). High blood pressure and associated symptoms were reduced by massage therapy. <i>Journal of Bodywork and Movement Therapies</i> , 4(1), 31-38.	Does not report data for MDD
Hick, S. F., and Chan, L. (2010). Mindfulness-based cognitive therapy for depression: effectiveness and limitations. <i>Social Work in Mental Health</i> , 8(3), 225-237. doi: 10.1080/15332980903405330	Nonsystematic review
Hidderley, M., and Holt, M. (2004). A pilot randomized trial assessing the effects of autogenic training in early stage cancer patients in relation to psychological status and immune system responses. <i>European Journal of Oncology Nursing</i> , 8(1), 61-65. doi: 10.1016/j.ejon.2003.09.003	Does not report data for MDD
Hill, K., Smith, R., Fearn, M., Rydberg, M., and Oliphant, R. (2007). Physical and psychological outcomes of a supported physical activity program for older carers. <i>Journal of Aging and Physical Activity</i> , 15(3), 257-271.	Does not report data for MDD
Hofmann, S. G., Sawyer, A. T., and Fang, A. (2010). The empirical status of the "new wave" of cognitive behavioral therapy. <i>Psychiatric Clinics of North America</i> , 33(3), 701-710.	Nonsystematic review
Hofmann, S. G., Sawyer, A. T., Witt, A. A., and Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. <i>Journal of Consulting and Clinical Psychology</i> , 78(2), 169-183. doi: 10.1037/a0018555	Systematic review
Holland, J. C., Morrow, G. R., Schmale, A., Derogatis, L., Stefanek, M., Berenson, S., Carpenter, P.J., Breitbart, W., and Feldstein, M. (1991). A randomized clinical trial of alprazolam versus progressive muscle relaxation in cancer patients with anxiety and depressive symptoms. <i>Journal of Clinical Oncology</i> , 9(6), 1004-1011.	Does not report data for MDD
Hollon, S. D., and Ponniah, K. (2010). A review of empirically supported psychological therapies for mood disorders in adults. <i>Depression and Anxiety</i> , 27(10), 891-932. doi: 10.1002/da.20741	Systematic review

Publication	Exclusion Reason
Holloway, E. A., and West, R. J. (2007). Integrated breathing and relaxation training (the Papworth method) for adults with asthma in primary care: a randomised controlled trial. <i>Thorax</i> , 62(12), 1039-1042. doi: 10.1136/thx.2006.076430	Does not report data for MDD
Holtforth, M. G., and T. Krieger, "Expositionsbasierte Kognitive Therapie Bei Depressionen. = Evidence-Based Cognitive Therapy for Patients with Depression," <i>Nervenheilkunde: Zeitschrift für interdisziplinäre Fortbildung</i> , Vol. 33, No. 4, 2014, pp. 252-258. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2014-14690-003&site=ehost-live	Not in English
Hoppes, K. (2006). The application of mindfulness-based cognitive interventions in the treatment of co-occurring addictive and mood disorders. <i>CNS Spectrums</i> , 11(11), 829-851.	Nonsystematic review
Horowitz, S. (2009). Evidence-based health benefits of qigong. <i>Alternative and Complementary Therapies</i> , 15(4), 178-183.	Nonsystematic review
Horrigan, B. J. (2007). New studies support the therapeutic value of meditation. <i>Explore: The Journal of Science and Healing</i> , 3(5), 449-452.	Does not report data for MDD
Hosseinzadeh, N., and Barahmand, U. (2014). "Effectiveness of mindfulness-based cognitive therapy for co-morbid depression in drug-dependent males," <i>Archives of Psychiatric Nursing</i> , 28, 314-318.	Does not report data for MDD
Hou, R. J., Wong, S. Y., Yip, B. H., Hung, A. T., Lo, H. H., Chan, P. H., Ma, S. H. (2013). The effects of mindfulness-based stress reduction program on the mental health of family caregivers: a randomized controlled trial. <i>Psychotherapy and psychosomatics</i> , 83(1), 45-53. doi: 10.1159/000353278	Does not report data for MDD
Hsieh, C. (2012). Enhancing self-management of depression risk through the integration of mindfulness practice and personal music usage. <i>International Journal of Psychology</i> , 47, 429-429.	Does not report data for MDD
Hudson, F. (2009). Mindfulness based cognitive therapy (MBCT) and occupational therapy in mental health. <i>Mental Health Occupational Therapy</i> , 14(2), 82-83.	Conference proceeding
Huffziger, S., Ebner-Priemer, U., Eisenbach, C., Koudela, S., Reinhard, I., Zamoscik, V., . . . Kuehner, C. (2013). Induced ruminative and mindful attention in everyday life: an experimental ambulatory assessment study. <i>Journal of Behavior Therapy and Experimental Psychiatry</i> , 44(3), 322-328. doi: 10.1016/j.jbtep.2013.01.007	Does not report data for MDD
Huffziger, S., and Kuehner, C. (2009). Rumination, distraction, and mindful self-focus in depressed patients. <i>Behaviour Research and Therapy</i> , 47(3), 224-230. doi: 10.1016/j.brat.2008.12.005	Does not report data for MDD
Hughes, A., Williams, M., Bardacke, N., Duncan, L. G., Dimidjian, S., and Goodman, S. H. (2009). Mindfulness approaches to childbirth and parenting. <i>British Journal of Midwifery</i> , 17(10), 630-635.	Nonsystematic review
Hurley, R. V., Patterson, T. G., and Cooley, S. J. (2013). Meditation-based interventions for family caregivers of people with dementia: a review of the empirical literature. <i>Aging & Mental Health</i> . doi: 10.1080/13607863.2013.837145	Systematic review
Idusohan-Moizer, H., Sawicka, A., Dendle, J., and Albany, M. (2013). Mindfulness-based cognitive therapy for adults with intellectual disabilities: an evaluation of the effectiveness of mindfulness in reducing symptoms of depression and anxiety. <i>Journal of Intellectual Disability Research</i> . doi: 10.1111/jir.12082	Does not report data for MDD
Igná, R. (2011). Effectiveness of mindfulness-based interventions in chronic pain: A meta-analysis. Highlighting the effectiveness of mindfulness-based interventions in chronic pain. A meta-analytic review. <i>Erdélyi Pszichológiai Szemle</i> , 12(1), 43-57.	Does not report data for MDD

Publication	Exclusion Reason
Isa, M. R., Moy, F. M., Abdul Razack, A. H., Zainuddin, Z. M., and Zainal, N. Z. (2013). Impact of applied progressive deep muscle relaxation training on the level of depression, anxiety and stress among prostate cancer patients: a quasi-experimental study. <i>Asian Pacific Journal of Cancer Prevention</i> , 14(4), 2237-2242.	Does not report data for MDD
Ivanovski, B., and Malhi, G. S. (2007). The psychological and neurophysiological concomitants of mindfulness forms of meditation. <i>Acta Neuropsychiatrica</i> , 19(2), 76-91. doi: 10.1111/j.1601-5215.2007.00175.x	Systematic review
Jain, F. A., I. A. Cook, A. F. Leuchter, A. M. Hunter, D. M. Davydov, C. Ottaviani, M. Tartter, C. Crump, and D. Shapiro, "Heart Rate Variability and Treatment Outcome in Major Depression: A Pilot Study," <i>Int J Psychophysiol</i> , Vol. 93, No. 2, Aug, 2014, pp. 204-210. http://ac.els-cdn.com/S0167876014000956/1-s2.0-S0167876014000956-main.pdf?_tid=a6eb0482-ce6e-11e4-8741-00000aabc362&acdnat=1426793717_b180a1e123f06c5349ec493e764e04df	Not RCT
Jain, F. A., Gitlin, M., and Lavretsky, H. (2012). Rapid response of major depressive disorder and comorbid eating disorder NOS to a novel meditation intervention. <i>Psychosomatics</i> , 53(4), 401-402. doi: 10.1016/j.psych.2012.03.006	Case report
Jain, F. A., and A. F. Leuchter, "Pilot Feasibility Study of Central Meditation and Imagery Therapy for Major Depressive Disorder," <i>Psychosomatic Medicine</i> , Vol. 76, No. 3, Apr, 2014, pp. A31-A31. <Go to ISI>://WOS:000334235100133	Abstract only
Jain, F. A., R. N. Walsh, S. J. Eisendrath, S. Christensen, and B. Rael Cahn, "Critical Analysis of the Efficacy of Meditation Therapies for Acute and Subacute Phase Treatment of Depressive Disorders: A Systematic Review," <i>Psychosomatics</i> , Oct 22, 2014. http://ac.els-cdn.com/S0033318214001674/1-s2.0-S0033318214001674-main.pdf?_tid=92a3c9c8-ce6e-11e4-ab6b-00000aabc0f01&acdnat=1426793683_8b522789b16538c04fb673708e083721	Systematic review
Jajvandian, R., Nabavi, S., Oryan, S., Samadi, S., Khani, H., and Nikravesh, A. (2011). Influence of 6-week yoga on depression and fatigue in patients with multiple sclerosis, North Khorasan, northeastern Iran. <i>Journal of Neurology</i> , 258, 95-96.	Does not report data for MDD
Janakiramaiah, N., Gangadhar, B. N., Naga Venkatesha Murthy, P. J., Harish, M. G., Subbakrishna, D. K., and Vadamurthachar, A. (2000). Antidepressant efficacy of Sudarshan Kriya Yoga (SKY) in melancholia: a randomized comparison with electroconvulsive therapy (ECT) and imipramine. <i>Journal of Affective Disorders</i> , 57(1-3), 255-259.	Does not report data for meditation for MDD
Jang, H. S., Lee, M. S., Kim, M. J., and Chong, E. S. (2004). Effects of Qi-therapy on premenstrual syndrome. <i>International Journal of Neuroscience</i> , 114(8), 909-921. doi: 10.1080/00207450490450163	Does not report data for MDD
Javanbakht, M., Morvarid, M., and Kenari, R. H. (2008). Effect of yoga on depression and anxiety of women referred to yoga clinic. <i>European Psychiatry</i> , 23, S213-S214. doi: 10.1016/j.eurpsy.2008.01.364	Does not report data for MDD
Javnbakht, M., Hejazi Kenari, R., and Ghasemi, M. (2009). Effects of yoga on depression and anxiety of women. <i>Complementary Therapies in Clinical Practice</i> , 15(2), 102-104. doi: 10.1016/j.ctcp.2009.01.003	Does not report data for MDD
Jayadevappa, R., Johnson, J. C., Bloom, B. S., Nidich, S., Desai, S., Chhatre, S., Raziano, D.B and Schneider, R. (2007). Effectiveness of transcendental meditation on functional capacity and quality of life of African Americans with congestive heart failure: a randomized control study. <i>Ethnicity & Disease</i> , 17(1), 72-77.	Does not report data for MDD
Jazaieri, H., Goldin, P. R., Werner, K., Ziv, M., and Gross, J. J. (2012). A randomized trial of MBSR versus aerobic exercise for social anxiety disorder. <i>Journal of Clinical Psychology</i> , 68(7), 715-731. doi: 10.1002/jclp.21863	Does not report data for MDD

Publication	Exclusion Reason
Jin, Putai. (1989). Changes in heart rate, noradrenaline, cortisol and mood during Tai Chi. <i>Journal of Psychosomatic Research</i> , 33(2), 197-206. doi: 10.1016/0022-3999(89)90047-0	Does not report data for MDD
John, P. J., Sharma, N., Sharma, C. M., and Kankane, A. (2007). Effectiveness of yoga therapy in the treatment of migraine without aura: a randomized controlled trial. <i>Headache</i> , 47(5), 654-661. doi: 10.1111/j.1526-4610.2007.00789.x	Does not report data for MDD
Jonsson, U., I. Alaie, T. Parling, and F. K. Arnberg, "Reporting of Harms in Randomized Controlled Trials of Psychological Interventions for Mental and Behavioral Disorders: A Review of Current Practice," <i>Contemporary Clinical Trials</i> , Vol. 38, No. 1, 2014, pp. 1-8. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L372610498	Background
Joo, H. M., Lee, S. J., Chung, Y. G., and Shin, I. Y. (2010). Effects of mindfulness based stress reduction program on depression, anxiety and stress in patients with aneurysmal subarachnoid hemorrhage. <i>Journal of Korean Neurosurgical Society</i> , 47(5), 345-351. doi: 10.3340/jkns.2010.47.5.345	Does not report data for MDD
Jorm, A. F., Christensen, H., Griffiths, K. M., and Rodgers, B. (2002). Effectiveness of complementary and self-help treatments for depression. <i>Medical Journal of Australia</i> , 176 Suppl, S84-96.	Systematic review
Jorm, A. F., Morgan, A. J., and Hetrick, S. E. (2008). Relaxation for depression. <i>Cochrane Database of Systematic Reviews (CDSR)</i> (4), CD007142. doi: 10.1002/14651858.CD007142.pub2	Systematic review
Josefsson, T., Lindwall, M., and Archer, T. (2013). Physical exercise intervention in depressive disorders: Meta-analysis and systematic review. <i>Scandinavian Journal of Medicine & Science in Sports</i> . doi: 10.1111/sms.12050	Systematic review
Judge, L., Cleghorn, A., McEwan, K., and Gilbert, P. (2012). An exploration of group-based compassion focused therapy for a heterogeneous range of clients presenting to a community mental health team. <i>International Journal of Cognitive Therapy</i> , 5(4), 420-429.	Does not report data for MDD
Kabat-Zinn, J., Lipworth, L., and Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. <i>Journal of Behavioral Medicine</i> , 8(2), 163-190.	Does not report data for MDD
Kabat-Zinn, J., Massion, A. O., Kristeller, J., Peterson, L. G., Fletcher, K. E., Pbert, L., Lenderking W. R., Santorelli, S. F. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. <i>American Journal of Psychiatry</i> , 149(7), 936-943.	Does not report data for MDD
Kabat-Zinn, Jon. (2003). Mindfulness-based stress reduction (MBSR). <i>Constructivism in the Human Sciences</i> , 8(2), 73-107.	Does not report data for MDD
Kahl, K. G., Winter, L., and Schweiger, U. (2012). The third wave of cognitive behavioural therapies: what is new and what is effective? <i>Current Opinion in Psychiatry</i> , 25(6), 522-528. doi: 10.1097/YCO.0b013e328358e531	Nonsystematic review
Kang, Y. S., Choi, S. Y., and Ryu, E. (2009). The effectiveness of a stress coping program based on mindfulness meditation on the stress, anxiety, and depression experienced by nursing students in Korea. <i>Nurse Education Today</i> , 29(5), 538-543. doi: 10.1016/j.nedt.2008.12.003	Does not report data for MDD

Publication	Exclusion Reason
Kangas, M., "The Evolution of Mindfulness-Based Cognitive Therapy," <i>Australian Psychologist</i> , Vol. 49, No. 5, Oct, 2014, pp. 280-282. <Go to ISI>://WOS:000341516300002 http://onlinelibrary.wiley.com/store/10.1111/ap.12072/asset/ap12072.pdf?v=1&t=i7gk0hle&s=518663448d5a499c8e03353f90ffb02d0effaf23	Background
Kaplan, K. H., Goldenberg, D. L., and Galvin-Nadeau, M. (1993). The impact of a meditation-based stress reduction program on fibromyalgia. <i>General Hospital Psychiatry</i> , 15(5), 284-289.	Does not report data for MDD
Kashef, Z. (2009). Simple solutions. Lift depression with meditation. <i>Natural Solutions</i> (119), 77-77.	Does not report data for MDD
Kaviani, H., Javaheri, F., and Hatami, N. (2011). Mindfulness-based cognitive therapy (MBCT) reduces depression and anxiety induced by real stressful setting in non-clinical population. <i>International Journal of Psychology and Psychological Therapy</i> , 11(2), 285-296.	Does not report data for MDD
Kaye, V. G. (1985). An innovative treatment modality for elderly residents of a nursing home. <i>Clinical Gerontologist: The Journal of Aging and Mental Health</i> , 3(4), 45-51. doi: 10.1300/J018v03n04_05	Does not report data for MDD
Kearney, D. J., Malte, C. A., McManus, C., Martinez, M. E., Felleman, B., and Simpson, T. L. (2013). Loving-kindness meditation for posttraumatic stress disorder: a pilot study. <i>Journal of Traumatic Stress</i> , 26(4), 426-434. doi: 10.1002/jts.21832	Does not report data for MDD
Kearney, D. J., McDermott, K., Malte, C., Martinez, M., and Simpson, T. L. (2013). Effects of participation in a mindfulness program for veterans with posttraumatic stress disorder: a randomized controlled pilot study. <i>Journal of Clinical Psychology</i> , 69(1), 14-27. doi: 10.1002/jclp.21911	Does not report data for MDD
Kearney, D. J., Milton, M. L., Malte, C. A., McDermott, K. A., Martinez, M., and Simpson, T. L. (2012). Participation in mindfulness-based stress reduction is not associated with reductions in emotional eating or uncontrolled eating. <i>Nutrition Research</i> , 32(6), 413-420. doi: 10.1016/j.nutres.2012.05.008	Does not report data for MDD
Kearney, D. J., McDermott, K., Malte, C. A., Martinez, M. E., and Simpson, T. L. (2012). Association of participation in a mindfulness program with measures of PTSD, depression and quality of life in a veteran sample. <i>Journal of Clinical Psychology</i> , 68(1), 101-116. doi: http://dx.doi.org/10.1002/jclp.20853	Does not report data for MDD
Keng, S. L., Smoski, M. J., and Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. <i>Clinical Psychology Review</i> , 31(6), 1041-1056.	Nonsystematic review
Keune, P. M., Bostanov, V., Hautzinger, M., and Kotchoubey, B. (2013). Approaching dysphoric mood: state-effects of mindfulness meditation on frontal brain asymmetry. <i>Biological Psychology</i> , 93(1), 105-113. doi: 10.1016/j.biopsycho.2013.01.016	Does not report data for MDD
Keune, P. M., Bostanov, V., Kotchoubey, B., and Hautzinger, M. (2009). Psychophysiological effects of enhanced sustained attention in recurrently depressed patients after mindfulness training. <i>Psychophysiology</i> , 46, S125-S125.	Conference proceeding
Khalsa, S. B. (2004). Yoga as a therapeutic intervention: a bibliometric analysis of published research studies. <i>Indian Journal of Physiology and Pharmacology</i> , 48(3), 269-285.	Nonsystematic review
Khalsa, S. B., Shorter, S. M., Cope, S., Wyshak, G., and Sklar, E. (2009). Yoga ameliorates performance anxiety and mood disturbance in young professional musicians. <i>Applied Psychophysiology and Biofeedback</i> , 34(4), 279-289. doi: 10.1007/s10484-009-9103-4	Does not report data for MDD

Publication	Exclusion Reason
Khoury, B., Lecomte, T., Comtois, G., and Nicole, L. (2013). Third-wave strategies for emotion regulation in early psychosis: a pilot study. <i>Early Intervention in Psychiatry</i> . doi: 10.1111/eip.12095	Does not report data for MDD
Khoury, B., Lecomte, T., Fortin, G., Masse, M., Therien, P., Bouchard, V., . . . Hofmann, S. G. (2013). Mindfulness-based therapy: a comprehensive meta-analysis. <i>Clinical Psychology Review</i> , 33(6), 763-771. doi: 10.1016/j.cpr.2013.05.005	Systematic review
Khumar, S. S., Kaur, P. and Kaur, S. (1993) Effectiveness of Shavasana on depression among university students. <i>Indian Journal of Clinical Psychology</i> . 20:82-87.	Not MBCT
Kim, B., Cho, S. J., Lee, K. S., Lee, J. Y., Choe, A. Y., Lee, J. E., . . . Lee, S. H. (2013). Factors associated with treatment outcomes in mindfulness-based cognitive therapy for panic disorder. <i>Yonsei Medical Journal</i> , 54(6), 1454-1462. doi: 10.3349/ymj.2013.54.6.1454	Does not report data for MDD
Kim, B., Lee, S. H., Kim, Y. W., Choi, T. K., Yook, K., Suh, S. Y., Cho, S. J. and Yook, K. H. (2010). Effectiveness of a mindfulness-based cognitive therapy program as an adjunct to pharmacotherapy in patients with panic disorder. <i>Journal of Anxiety Disorders</i> , 24(6), 590-595. doi: 10.1016/j.janxdis.2010.03.019	Does not report data for MDD
Kim, J. H., Yang, H., and Schroepel, S. (2013). A pilot study examining the effects of kouk sun do on university students with anxiety symptoms. <i>Stress and Health</i> , 29(2), 99-107. doi: 10.1002/smi.2431	Does not report data for MDD
Kim, S. H., Schneider, S. M., Kravitz, L., Mermier, C., and Burge, M. R. (2013). Mind-body practices for posttraumatic stress disorder. <i>J Investig Med</i> , 61(5), 827-834. doi: 10.231/JIM.0b013e3182906862	Does not report data for MDD
Kim, Y. H., Kim, H. J., Ahn, S. D., Seo, Y. J., and Kim, S. H. (2013). Effects of meditation on anxiety, depression, fatigue, and quality of life of women undergoing radiation therapy for breast cancer. <i>Complementary Therapies in Medicine</i> , 21(4), 379-387. doi: 10.1016/j.ctim.2013.06.005	Does not report data for MDD
Kim, Y. W., Lee S. H., Choi, T. K., Suh, S. Y., Kim, B., Kim, C. M., Cho, S. J., Kim, M. J., Yook, K., Ryu, M., Song, S. K. and Yook, K. H. (2009). Effectiveness of mindfulness-based cognitive therapy as an adjuvant to pharmacotherapy in patients with panic disorder or generalized anxiety disorder. <i>Depression and Anxiety</i> , 26(7), 601-606. doi: 10.1002/da.20552	Does not report data for MDD
Kimbrough, E., Magyari, T., Langenberg, P., Chesney, M., and Berman, B. (2010). Mindfulness intervention for child abuse survivors. <i>Journal of Clinical Psychology</i> , 66(1), 17-33. doi: 10.1002/jclp.20624	Does not report data for MDD
Kinser, P. A., Bourguignon, C., Whaley, D., Hauenstein, E. and Taylor, A. G. (2013). "Feasibility, acceptability, and effects of gentle hatha yoga for women with major depression: findings from a randomized controlled mixed-methods study," <i>Archives Psychiatr Nursing</i> , 27 (3), 137-147.	Does not report data for MDD
Kinser, P. A., Elswick, R., and Kornstein, S. (2014). "Potential long-term effects of a mind-body intervention for women with major depressive disorder: sustained mental health improvements with a pilot yoga intervention," <i>Archives of Psychiatric Nursing</i> , 28 (6), 377-383.	Does not report data for MDD
Kingston, T. Dooley, B. Bates, A. Lawlor, E. and Malone. K. (2007). Mindfulness-based cognitive therapy for residual depressive symptoms. <i>Psychology and Psychotherapy: Theory, Research and Practice</i> , 80, 193-203.	Not RCT

Publication	Exclusion Reason
Kitsumban, V., Thapinta, D., Sirindharo, P. B. and Anders, R. L. (2009). "Effect of cognitive mindfulness practice program on depression among elderly Thai women," <i>Thai Journal of Nursing Research</i> , 13 (2), 95-107. http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2010323274&site=ehost-live	Does not report data for MDD
Klainin-Yobas, P., Cho, M. A., and Creedy, D. (2012). Efficacy of mindfulness-based interventions on depressive symptoms among people with mental disorders: a meta-analysis. <i>International Journal of Nursing Studies</i> , 49(1), 109-121. doi: 10.1016/j.ijnurstu.2011.08.014	Systematic review
Klainin-Yobas, P., W. N. Oo, P. Y. Suzanne Yew, and Y. Lau, "Effects of Relaxation Interventions on Depression and Anxiety among Older Adults: A Systematic Review," <i>Aging Ment Health</i> , Jan 9, 2015, pp. 1-13. http://www.tandfonline.com/doi/pdf/10.1080/13607863.2014.997191	Systematic review
Klein, M. H., (1984). "A comparative outcome study of group psychotherapy vs. exercise treatments for depression," <i>International Journal of Mental Health</i> , 13(3-4), 148-176. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1985-20662-001&site=ehost-live	Does not report data for MDD
Kluepfel, L., Ward, T., Yehuda, R., Dimoulas, E., Smith, A., and Daly, K. (2013). The evaluation of mindfulness-based stress reduction for veterans with mental health conditions. <i>Journal of Holistic Nursing</i> , 31(4), 248-255. doi: 10.1177/0898010113495975	Does not report data for MDD
Knight, M., Pultinas, D., Collins, S., Sellig, C., Freeman, D. C., Strimaitis, C., Simms, N. and Silver, R. R. (2012). Teaching mindfulness on an inpatient psychiatric unit. <i>Mindfulness</i> . doi: 10.1007/s12671-012-0175-5	Does not report relevant outcome data
Ko, Y. L., Yang, C. L., Fang, C. L., Lee, M. Y., and Lin, P. C. (2013). Community-based postpartum exercise program. <i>Journal of Clinical Nursing</i> , 22(15-16), 2122-2131. doi: 10.1111/jocn.12117	Does not report data for MDD
Kocovski, N. L., Fleming, J. E., Hawley, L. L., Huta, V., and Antony, M. M. (2013). Mindfulness and acceptance-based group therapy versus traditional cognitive behavioral group therapy for social anxiety disorder: A randomized controlled trial. <i>Behaviour Research and Therapy</i> , 51(12), 889-898. doi: 10.1016/j.brat.2013.10.007	Does not report data for MDD
Kocovski, N. L., Fleming, J. E., and Rector, N. A. (2009). Mindfulness and acceptance-based group therapy for social anxiety disorder: an open trial. <i>Cognitive and Behavioral Practice</i> , 16(3), 276-289.	Does not report data for MDD
Kohn, M., Persson Lundholm, U., Bryngelsson, I. L., Anderzen-Carlsson, A., and Westerdahl, E. (2013). Medical yoga for patients with stress-related symptoms and diagnoses in primary health care: a randomized controlled trial. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 215348. doi: 10.1155/2013/215348	Does not report data for MDD
Koszycki, D., Raab, K., Aldosary, F., and Bradwejn, J. (2010). A multifaith spiritually based intervention for generalized anxiety disorder: a pilot randomized trial. <i>Journal of Clinical Psychology</i> , 66(4), 430-441. doi: 10.1002/jclp.20663	Does not report data for MDD
Kozasa, E. H., Santos, R. F., Rueda, A. D., Benedito-Silva, A. A., De Ornellas, F. L., and Leite, J. R. (2008). Evaluation of Siddha Samadhi Yoga for anxiety and depression symptoms: a preliminary study. <i>Psychological Reports</i> , 103(1), 271-274.	Does not report data for MDD
Kraemer, J. M., and Marquez, D. X. (2009). Psychosocial correlates and outcomes of yoga or walking among older adults. <i>Journal of Psychology</i> , 143(4), 390-404. doi: 10.3200/jrlp.143.4.390-404	Does not report data for MDD

Publication	Exclusion Reason
Kraft, K. (2012). CAM for depression, anxiety, grief, and other symptoms in palliative care. <i>Progress in Palliative Care</i> , 20(5), 272-277.	Systematic review
Krishnamurthy, M. N., and Telles, S. (2007). Assessing depression following two ancient Indian interventions: effects of yoga and ayurveda on older adults in a residential home. <i>Journal of Gerontological Nursing</i> , 33(2), 17-23.	Does not report data for MDD
Krusche, A., Cyhlarova, E., and Williams, J. M. (2013). Mindfulness online: an evaluation of the feasibility of a web-based mindfulness course for stress, anxiety and depression. <i>BMJ Open</i> , 3(11), e003498. doi: 10.1136/bmjopen-2013-003498	Does not report data for MDD
Kubo, A., Hung, Y. Y., and Rittnerman, J. (2011). Yoga for heart failure patients: a feasibility pilot study with a multiethnic population. <i>International Journal of Yoga (IJoY)</i> (21), 77-83.	Does not report data for MDD
Kuehner, C., Huffziger, S., and Liebisch, K. (2009). Rumination, distraction and mindful self-focus: effects on mood, dysfunctional attitudes and cortisol stress response. <i>Psychological Medicine</i> , 39(2), 219-228. doi: 10.1017/s0033291708003553	Does not report data for MDD
Kumar, S., Feldman, G., and Hayes, A. (2008). Changes in mindfulness and emotion regulation in an exposure-based cognitive therapy for depression. <i>Cognitive Therapy and Research</i> , 32(6), 734-744. doi: 10.1007/s10608-008-9190-1	Does not report data for meditation for MDD
Kushner, M. G., Krueger, R. F., Wall, M. M., Maurer, E. W., Menk, J. S., and Menary, K. R. (2013). Modeling and treating internalizing psychopathology in a clinical trial: a latent variable structural equation modeling approach. <i>Psychological Medicine</i> , 43(8), 1611-1623. doi: 10.1017/s0033291712002772	Does not report data for MDD
Kutz, I., Leserman, J., Dorrington, C., Morrison, C. H., Borysenko, J. Z., and Benson, H. (1985). Meditation as an adjunct to psychotherapy: An outcome study. <i>Psychotherapy and Psychosomatics</i> , 43(4), 209-218. doi: 10.1159/000287881	Does not report data for MDD
Kuyken, W., S. Byford, R. Byng, T. Dalgleish, G. Lewis, R. Taylor, E. R. Watkins, R. Hayes, P. Lanham, D. Kessler, N. Morant, and A. Evans. (2014) "Update to the Study Protocol for a Randomized Controlled Trial Comparing Mindfulness-Based Cognitive Therapy with Maintenance Anti-Depressant Treatment Depressive Relapse/Recurrence: The Prevent Trial," <i>Trials</i> , Vol. 15: 217. http://www.trialsjournal.com/content/pdf/1745-6215-15-217.pdf	Study protocol
Kuyken, W., Crane, R., and Dalgleish, T. (2012). Does mindfulness based cognitive therapy prevent relapse of depression? <i>British Medical Journal</i> , 345, e7194. doi: 10.1136/bmj.e7194	Nonsystematic review
Labelle, L. E., Campbell, T. S., and Carlson, L. E. (2010). Mindfulness-based stress reduction in oncology: evaluating mindfulness and rumination as mediators of change in depressive symptoms. <i>Mindfulness</i> , 1-13.	Does not report data for MDD
Labus, J., Gupta, A., Gill, H. K., Posserud, I., Mayer, M., Raeen, H., Bolus, R., Simren, M., Naliboff, B. D., and Mayer, E. A. (2013). Randomised clinical trial: symptoms of the irritable bowel syndrome are improved by a psycho-education group intervention. <i>Alimentary Pharmacology & Therapeutics</i> , 37(3), 304-315. doi: 10.1111/apt.12171	Does not report data for MDD
Lake, J. (2004). The integrative management of depressed mood. <i>Integrative Medicine: A Clinician's Journal</i> , 3(3), 34-43.	Nonsystematic review
Lakhan, S. E., and Schofield, K. L. (2013). Mindfulness-based therapies in the treatment of somatization disorders: a systematic review and meta-analysis. <i>PLoS One</i> , 8(8), e71834. doi: 10.1371/journal.pone.0071834	Systematic review

Publication	Exclusion Reason
Lakkireddy, D., Atkins, D., Pillarisetti, J., Ryschon, K., Bommana, S., Drisko, J., Vanga, S., and Dawn, B. (2013). Effect of yoga on arrhythmia burden, anxiety, depression, and quality of life in paroxysmal atrial fibrillation: the YOGA My Heart Study. <i>Journal of the American College of Cardiology</i> , 61(11), 1177-1182. doi: 10.1016/j.jacc.2012.11.060	Does not report data for MDD
Lam, L. C., Chau, R. C., Wong, B. M., Fung, A. W., Tam, C. W., Leung, G. T., Kwok, T. CY., Leung, T., Ng, S. P., and Chan, W. M. (2012). A 1-year randomized controlled trial comparing mind body exercise (Tai Chi) with stretching and toning exercise on cognitive function in older Chinese adults at risk of cognitive decline. <i>Journal of the American Medical Directors Association</i> , 13(6), 568 e515-520. doi: 10.1016/j.jamda.2012.03.008	Does not report data for MDD
Lampe, L., Coulston, C. M., and Berk, L. (2013). Psychological management of unipolar depression. <i>Acta Psychiatrica Scandinavica Suppl</i> (443), 24-37. doi: 10.1111/acps.12123	Nonsystematic review
Langhorst, J., Klose, P., Dobos, G. J., Bernardy, K., and Hauser, W. (2013). Efficacy and safety of meditative movement therapies in fibromyalgia syndrome: a systematic review and meta-analysis of randomized controlled trials. <i>Rheumatology International</i> , 33(1), 193-207. doi: 10.1007/s00296-012-2360-1	Systematic review
Larzelere, M. M., and Wiseman, P. (2002a). Anxiety, depression, and insomnia. <i>Primary Care - Clinics in Office Practice</i> , 29(2), 339-360.	Nonsystematic review
Lau, M. A., Bishop, S. R., Segal, Z. V., Buis, T., Anderson, N. D., Carlson, L., Shapiro, S., Carmody, J., Abbey, S., and Devins, G. (2006). The Toronto mindfulness scale: development and validation. <i>Journal of Clinical Psychology</i> , 62(12), 1445-1467. doi: 10.1002/jclp.20326	Does not report data for MDD
Lauche, R., Cramer, H., Dobos, G., Langhorst, J., and Schmidt, S. (2013). A systematic review and meta-analysis of mindfulness-based stress reduction for the fibromyalgia syndrome. <i>Journal of Psychosomatic Research</i> , 75(6), 500-510. doi: 10.1016/j.jpsychores.2013.10.010	Systematic review
Lauche, R., Cramer, H., Hauser, W., Dobos, G., and Langhorst, J. (2013). A systematic review and meta-analysis of qigong for the fibromyalgia syndrome. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 635182. doi: 10.1155/2013/635182	Systematic review
Lavey, R., Sherman, T., Mueser, K. T., Osborne, D. D., Currier, M., and Wolfe, R. (2005). The effects of yoga on mood in psychiatric inpatients. <i>Psychiatric Rehabilitation Journal</i> , 28(4), 399-402.	Does not report data for MDD
Lavretsky, H. (2010). Complementary and alternative medicine use for treatment and prevention of late-life mood disorders. <i>Clinical Geriatrics</i> , 18(6), 32-37.	Systematic review
Lavretsky, H., Epel, E. S., Siddarth, P., Nazarian, N., Cyr, N. S., Khalsa, D. S., Lin, J., Blackburn, E., and Irwin, M. R. (2013). A pilot study of yogic meditation for family dementia caregivers with depressive symptoms: effects on mental health, cognition, and telomerase activity. <i>International Journal of Geriatric Psychiatry</i> , 28(1), 57-65. doi: 10.1002/gps.3790	Does not report data for MDD
Lavretsky, H., and Irwin, M. (2011). Meditation improves depressive symptoms, coping, cognition, and inflammation in family dementia caregivers in a randomized 8-week pilot study. <i>American Journal of Geriatric Psychiatry</i> , 19(3), S108-S109.	Does not report data for MDD
Lawrence, M., Booth, J., Mercer, S., and Crawford, E. (2013). A systematic review of the benefits of mindfulness-based interventions following transient ischemic attack and stroke. <i>International Journal of Stroke</i> , 8(6), 465-474. doi: 10.1111/ijis.12135	Systematic review

Publication	Exclusion Reason
Lee, E. N., Kim, Y. H., Chung, W. T., and Lee, M. S. (2008). Tai Chi for disease activity and flexibility in patients with ankylosing spondylitis--a controlled clinical trial. <i>Evidence-Based Complementary and Alternative Medicine</i> , 5(4), 457-462. doi: 10.1093/ecam/nem048	Does not report data for MDD
Lee, E. O., Chae, Y. R., Song, R., Eom, A., Lam, P., and Heitkemper, M. (2010). Feasibility and effects of a Tai Chi self-help education program for Korean gastric cancer survivors. <i>Oncology Nursing Forum</i> , 37(1), E1-6. doi: 10.1188/10.onf.e1-e6	Does not report data for MDD
Lee, K. H., Bowen, S., and An-Fu, B. (2011). Psychosocial outcomes of mindfulness-based relapse prevention in incarcerated substance abusers in Taiwan: A preliminary study. <i>Journal of Substance Use</i> , 16(6), 476-483. doi: 10.3109/14659891.2010.505999	Does not report data for MDD
Lee, M. S., Jang, J. W., Jang, H. S., and Moon, S. R. (2003). Effects of Qi-therapy on blood pressure, pain and psychological symptoms in the elderly: a randomized controlled pilot trial. <i>Complementary Therapies in Medicine</i> , 11(3), 159-164. doi: 10.1016/s0965-2299(03)00088-8	Does not report data for MDD
Lee, M. S., Jeong, S. M., Kim, B. G., Ryu, H., Oh, S. W., and Chung, H. T. (1999). A Minnesota multiphasic personality inventory profile of ChunDoSunBup Qi-trainees: a preliminary study. <i>American Journal of Chinese Medicine</i> , 27(3-4), 307-313. doi: 10.1142/s0192415x99000355	Does not report data for MDD
Lee, M. S., Pittler, M. H., and Ernst, E. (2007). Tai Chi for rheumatoid arthritis: systematic review. <i>Rheumatology (Oxford)</i> , 46(11), 1648-1651. doi: 10.1093/rheumatology/kem151	Systematic review
Lee, S. H., Ahn, S. C., Lee, Y. J., Choi, T. K., Yook, K. H., and Suh, S. Y. (2007). Effectiveness of a meditation-based stress management program as an adjunct to pharmacotherapy in patients with anxiety disorder. <i>Journal of Psychosomatic Research</i> , 62(2), 189-195. doi: 10.1016/j.jpsychores.2006.09.009	Does not report data for MDD
Lee, W. K., and Bang, H. J. (2010). The Effects of mindfulness-based group intervention on the mental health of middle-aged Korean women in community. <i>Stress and Health</i> , 26(4), 341-348. doi: 10.1002/smi.1303	Does not report data for MDD
Leite, J. R., Ornellas, F. L., Amemiya, T. M., de Almeida, A. A., Dias, A. A., Afonso, R., Little, S., and Kozasa, E. H. (2010a). Effect of progressive self-focus meditation on attention, anxiety, and depression scores. <i>Perceptual and Motor Skills</i> , 110(3 Pt 1), 840-848.	Does not report data for MDD
Lengacher, C. A., Johnson-Mallard, V., Post-White, J., Moscoso, M. S., Jacobsen, P. B., Klein, T. W., Widen, R. H., Fitzgerald, S. G., Shelton, M. M., Barta, M., Goodman, M., Charles E. Cox, C. E., and Kip, K. E. (2009). Randomized controlled trial of mindfulness-based stress reduction (MBSR) for survivors of breast cancer. <i>Psychooncology</i> , 18(12), 1261-1272. doi: 10.1002/pon.1529	Does not report data for MDD
Leon-Pizarro, C., Gich, I., Barthe, E., Rovirosa, A., Farrus, B., Casas, F., Verger, E., Biete, A., Craven-Bartle, J., Sierra, J. and Arcusa, A. (2007). A randomized trial of the effect of training in relaxation and guided imagery techniques in improving psychological and quality-of-life indices for gynecologic and breast brachytherapy patients. <i>Psycho-Oncology</i> , 16(11), 971-979. doi: 10.1002/pon.1171	Does not report data for MDD
Lerman, C., Rimer, B., Blumberg, B., Cristinzio, S., Engstrom, P. F., MacElwee, N., O'Connor, K., and Seay, J. (1990). Effects of coping style and relaxation on cancer chemotherapy side effects and emotional responses. <i>Cancer Nursing</i> , 13(5), 308-315.	Does not report data for MDD

Publication	Exclusion Reason
Leverone, D., and Epstein, B. J. (2010). Nonpharmacological interventions for the treatment of rheumatoid arthritis: A focus on mind-body medicine. <i>Journal of Pharmacy Practice</i> , 23(2), 101-109.	Systematic review
Li, D. X., Zhuang, X. Y., Zhang, Y. P., Guo, H., Wang, Z., Zhang, Q., Feng, Y. M., and Yao Y.G. (2013). Effects of Tai Chi on the protracted abstinence syndrome: a time trial analysis <i>Am J Chin Med</i> , 41(1), 43-57	Does not report data for MDD
Li, F. Z., Duncan, T. E., Duncan, S. C., McAuley, E., Chaumeton, N. R., and Harmer, P. (2001). Enhancing the psychological well-being of elderly individuals through Tai Chi exercise: a latent growth curve analysis. <i>Structural Equation Modeling-a Multidisciplinary Journal</i> , 8(1), 53-83. doi: 10.1207/s15328007sem0801_4	Does not report data for MDD
Lin, K. Y., Hu, Y. T., Chang, K. J., Lin, H. F., and Tsauo, J. Y. (2011). Effects of yoga on psychological health, quality of life, and physical health of patients with cancer: a meta-analysis. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2011, 659876. doi: 10.1155/2011/659876	Systematic review
Litchke, Lyn G., Hodges, Jan S., and Reardon, Robert F. (2012). Benefits of chair yoga for persons with mild to severe alzheimer's disease. <i>Activities, Adaptation and Aging</i> , 36(4), 317-328. doi: 10.1080/01924788.2012.729185	Does not report data for MDD
Little, S. A. S., Kligler, B., Homel, P., Belisle, S. S., and Merrell, W. (2009). Multimodal mind/body group therapy for chronic depression: a pilot study. <i>Explore-the Journal of Science and Healing</i> , 5(6), 330-337. doi: 10.1016/j.explore.2009.08.004	Does not report data for MDD
Liu, X., Miller, Y. D., Burton, N. W., and Brown, W. J. (2010). A preliminary study of the effects of Tai Chi and qigong medical exercise on indicators of metabolic syndrome, glycaemic control, health-related quality of life, and psychological health in adults with elevated blood glucose. <i>British Journal of Sports Medicine</i> , 44(10), 704-709. doi: 10.1136/bjsm.2008.051144	Does not report data for MDD
Liu, X., Vitetta, L., Kostner, K., Crompton, D., Williams, G., Brown, W. J., Lopez, A., Xue, C. C., Oei, T. P., and Byrne, G. (2015). "The effects of Tai Chi in centrally obese adults with depression symptoms," <i>Evidence-Based Complementary and Alternative Medicine</i> , Vol. 2015.	Does not report data for MDD
Ljotsson, B., Andreewitch, S., Hedman, E., Ruck, C., Andersson, G., and Lindefors, N. (2010). Exposure and mindfulness based therapy for irritable bowel syndrome - an open pilot study. <i>Journal of Behavior Therapy and Experimental Psychiatry</i> , 41(3), 185-190. doi: 10.1016/j.jbtep.2010.01.001	Does not report data for MDD
Ljotsson, B., Atterlof, E., Lagerlof, M., Andersson, E., Jernelov, S., Hedman, E., . . . Wicksell, R. K. (2013). Internet-Delivered Acceptance and Values-Based Exposure Treatment for Fibromyalgia: A Pilot Study. <i>Cognitive behaviour therapy</i> , 43(2), 93-104. doi: 10.1080/16506073.2013.846401	Does not report data for MDD
Ljotsson, B., Falk, L., Vesterlund, A. W., Hedman, E., Lindfors, P., Ruck, C., Hursti, T., Andréewitchm, S., Jansson, L., Lindefors, N., Andersson, G. (2010). Internet-delivered exposure and mindfulness based therapy for irritable bowel syndrome--a randomized controlled trial. <i>Behaviour Research and Therapy</i> , 48(6), 531-539. doi: 10.1016/j.brat.2010.03.003	Does not report data for MDD
Lloyd, D. P., Rosow, J. D., and Hillbrand, M. (2012). Integrative medicine improves mood in an inpatient setting. <i>Psychiatric Services</i> , 63(11), 1154-1155.	Does not report data for MDD
Lo, C. S. L., S. M. Y. Ho, N. K. K. Yu, and B. P. Y. Siu, "Decentering Mediates the Effect of Ruminative and Experiential Self-Focus on Negative Thinking in Depression," <i>Cognitive Therapy and Research</i> , Vol. 38, No. 4, Aug, 2014, pp. 389-396. <Go to	Does not report relevant outcome data

Publication	Exclusion Reason
ISI>://WOS:000339382000003 http://download.springer.com/static/pdf/565/art%253A10.1007%252Fs10608-014-9603-2.pdf?auth66=1426794650_9b120d3a445487c8589e36e13ce90d04&ext=.pdf	
Lo, H. H. M., "Applications of Buddhist Compassion Practices among People Suffering from Depression and Anxiety in Confucian Societies in East Asia," <i>Journal of Religion & Spirituality in Social Work</i> , Vol. 33, No. 1, 2014 Jan-Mar, 2014, pp. 19-32. http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2012484708&site=ehost-live	Not MBCT
Lo, H. H., S. M. Ng, C. L. Chan, K. Lam, and B. H. Lau, "The chinese medicine construct "stagnation" in mind-body connection mediates the effects of mindfulness training on depression and anxiety," <i>Complementary Therapies in Medicine</i> , Vol. 21, No. 4, 2013, pp. 348-357.	Not MBCT
Loizzo, J. J., Peterson, J. C., Charlson, M. E., Wolf, E. J., Altemus, M., Briggs, W. M., Vahdat, L. T., Caputo, T. A. (2010). The effect of a contemplative self-healing program on quality of life in women with breast and gynecologic cancers. <i>Alternative Therapies in Health and Medicine</i> , 16(3), 30-37.	Does not report data for MDD
Lolak, S., Connors, G. L., Sheridan, M. J., and Wise, T. N. (2008). Effects of progressive muscle relaxation training on anxiety and depression in patients enrolled in an outpatient pulmonary rehabilitation program. <i>Psychotherapy and psychosomatics</i> , 77(2), 119-125. doi: 10.1159/000112889	Does not report data for MDD
Lombardi, F., Belletti, S., and Lomuscio, A. (2013). Alternative therapies in the treatment of atrial fibrillation. <i>Journal of Atrial Fibrillation</i> , 5(6), 175-181.	Does not report data for MDD
Longacre, M., Silver-Highfield, E., Lama, P., and Grodin, M. (2012). Complementary and alternative medicine in the treatment of refugees and survivors of torture: a review and proposal for action. <i>Torture</i> , 22(1), 38-57.	Systematic review
Louie, L., "The Effectiveness of Yoga for Depression: A Critical Literature Review," <i>Issues Ment Health Nurs</i> , Vol. 35, No. 4, Apr, 2014, pp. 265-276. http://informahealthcare.com/doi/abs/10.3109/01612840.2013.874062	Review
Luberto, C. M., White, C., Sears, R. W., and Cotton, S. (2013a). Integrative medicine for treating depression: an update on the latest evidence. <i>Current Psychiatry Reports</i> , 15(9). doi: 10.1007/s11920-013-0391-2	Systematic review
Lush, E., Salmon, P., Floyd, A., Studts, J. L., Weissbecker, I., and Sephton, S. E. (2009a). Mindfulness meditation for symptom reduction in Fibromyalgia: Psychophysiological correlates. <i>Journal of Clinical Psychology in Medical Settings</i> , 16(2), 200-207.	Does not report data for MDD
Ly, K. H., A. Trüschel, L. Jarl, S. Magnusson, T. Windahl, R. Johansson, P. Carlbring, and G. Andersson, "Behavioural activation versus mindfulness-based guided self-help treatment administered through a smartphone application: A randomised controlled trial," <i>BMJ Open</i> , Vol. 4, No. 1, 2014, p. e003440.	Not MBCT
Lyles, J. N., Burish, T. G., Krozely, M. G., and Oldham, R. K. (1982). Efficacy of relaxation training and guided imagery in reducing the aversiveness of cancer chemotherapy. <i>Journal of Consulting and Clinical Psychology</i> , 50(4), 509-524. doi: 10.1037/0022-006X.50.4.509	Does not report data for MDD
Lynn, S. J., and Condon, L. P. (2013). Review of experimental and quasi-experimental studies finds that mindfulness-based interventions are more effective than standard care for reducing depressive symptoms in adults with mental disorders. <i>Evidence-Based Nursing</i> , 16(1), 12-13. doi: 10.1136/eb-2012-100700	Background

Publication	Exclusion Reason
Maddali, B. S., Del Rosso, A., Di Felice, C., Calà, M., and Giambalvo, D. B. G. (2012). Resseguier method and Qigong sequentially integrated in patients with fibromyalgia syndrome. <i>Clinical and Experimental Rheumatology</i> , 30(6 Suppl 74), 51-58.	Does not report data for MDD
Majid, S. A., Seghatoleslam, T., Homan, H. A., Akhvast, A., and Habil, H. (2012). Effect of mindfulness based stress management on reduction of generalized anxiety disorder. <i>Iranian Journal of Public Health</i> , 41(10), 24-28.	Does not report data for MDD
Malarkey, W. B., Jarjoura, D., and Klatt, M. (2013). Workplace based mindfulness practice and inflammation: a randomized trial. <i>Brain, Behavior, and Immunity</i> , 27(1), 145-154. doi: 10.1016/j.bbi.2012.10.009	Does not report data for MDD
Malchow, B., Reich-Erkelenz, D., Oertel-Knochel, V., Keller, K., Hasan, A., Schmitt, A., Scheewe, T. W., Cahn, W., Kahn, R. S., and Falkai, P. (2013). The effects of physical exercise in schizophrenia and affective disorders. <i>European Archives of Psychiatry and Clinical Neuroscience</i> , 263(6), 451-467. doi: 10.1007/s00406-013-0423-2	Does not report data for meditation for MDD
Mamtani, R., and Cimino, A. (2002). A primer of complementary and alternative medicine and its relevance in the treatment of mental health problems. <i>Psychiatric Quarterly</i> , 73(4), 367-381.	Does not report data for meditation for MDD
Manheimer, E., Wieland, S., Kimbrough, E., Cheng, K., and Berman, B. M. (2009). Evidence from the cochrane collaboration for traditional chinese medicine therapies. <i>Journal of Alternative and Complementary Medicine</i> , 15(9), 1001-1014.	Does not report data for meditation for MDD
Manjunath, R. B., Varambally, S., Thirthalli, J., Basavaraddi, I. V., and Gangadhar, B. N. (2013). Efficacy of yoga as an add-on treatment for in-patients with functional psychotic disorder. <i>Indian Journal of Psychiatry</i> , 55(Suppl 3), S374-378. doi: 10.4103/0019-5545.116314	Does not report data for MDD
Manotas, M., Segura, C., Eraso, M., Oggins, J., and McGovern, K. (2013). Association of brief mindfulness training with reductions in perceived stress and distress in colombian health care professionals. <i>International Journal of Stress Management</i> . doi: 10.1037/a0035150	Does not report data for MDD
Manzaneque, J. M., Vera, F. M., Godoy, Y. A., Ramos, N. S., Rodriguez, F. M., Blanca, M. J., Fernandez, A., Enguix, A., and Iglesias, M. R. (2010). Immunomodulatory effects in anxious and depressed patients after a mindfulness meditation program. <i>International Journal of Behavioral Medicine</i> , 17, 179-179.	Conference proceeding
Manzaneque, J. M., Vera, F. M., Ramos, N. S., Godoy, Y. A., Rodriguez, F. M., Blanca, M. J., Fernandez, A., Enguix, A. (2011). Psychobiological modulation in anxious and depressed patients after a mindfulness meditation programme: a pilot study. <i>Stress and Health</i> , 27(3), 216-222. doi: 10.1002/smi.1334	Does not report data for MDD
Manzaneque, J. M., Vera, F. M., Rodriguez, F. M., Garcia, G. J., Leyva, L., and Blanca, M. J. (2009). Serum cytokines, mood and sleep after a qigong program: is Qigong an effective psychobiological tool? <i>Journal of Health Psychology</i> , 14(1), 60-67. doi: 10.1177/1359105308097946	Does not report data for MDD
Marchand, W. R. (2012). Mindfulness-based stress reduction, mindfulness-based cognitive therapy, and Zen meditation for depression, anxiety, pain, and psychological distress. <i>Journal of Psychiatric Practice</i> , 18(4), 233-252. doi: 10.1097/01.pra.0000416014.53215.86	Nonsystematic review

Publication	Exclusion Reason
Marchand, W. R. (2013). Mindfulness meditation practices as adjunctive treatments for psychiatric disorders. <i>Psychiatric Clinics of North America</i> , 36(1), 141-152. doi: 10.1016/j.psc.2013.01.002	Nonsystematic review
Mars, T. S., and Abbey, H. (2010). Mindfulness meditation practise as a healthcare intervention: a systematic review. <i>International Journal of Osteopathic Medicine</i> , 13(2), 56-66. doi: 10.1016/j.ijosm.2009.07.005	Systematic review
Martinez-Devesa, P., Perera, R., Theodoulou, M., and Waddell, A. (2010). Cognitive behavioural therapy for tinnitus. <i>Cochrane Database of Systematic Reviews (CDSR)</i> (9), CD005233. doi: 10.1002/14651858.CD005233.pub3	Does not report data for meditation for MDD
Martinsen, Egil W. (1987). The role of aerobic exercise in the treatment of depression. <i>Stress Medicine</i> , 3(2), 93-100. doi: 10.1002/smi.2460030205	Systematic review
Matchim, Y., Armer, J. M., and Stewart, B. R. (2011). Mindfulness-based stress reduction among breast cancer survivors: a literature review and discussion. <i>Oncology Nursing Forum</i> , 38(2), E61-71. doi: 10.1188/11.onf.e61-e71	Systematic review
Mathew, K. L., Whitford, H. S., Kenny, M. A., and Denson, L. A. (2010). The long-term effects of mindfulness-based cognitive therapy as a relapse prevention treatment for major depressive disorder. <i>Behavioural and Cognitive Psychotherapy</i> , 38(5), 561-576. doi: 10.1017/s135246581000010x	Does not report data for MDD
Matousek, R. H., and Dobkin, P. L. (2010). Weathering storms: a cohort study of how participation in a mindfulness-based stress reduction program benefits women after breast cancer treatment. <i>Current Oncology</i> , 17(4), 62-70.	Does not report data for MDD
Matousek, R. H., Pruessner, J. C., and Dobkin, P. L. (2011). Changes in the cortisol awakening response (CAR) following participation in mindfulness-based stress reduction in women who completed treatment for breast cancer. <i>Complementary Therapies in Clinical Practice</i> , 17(2), 65-70. doi: 10.1016/j.ctcp.2010.10.005	Does not report data for MDD
McCall, M. C., Ward, A., Roberts, N. W., and Heneghan, C. (2013). Overview of systematic reviews: yoga as a therapeutic intervention for adults with acute and chronic health conditions. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 945895. doi: 10.1155/2013/945895	Systematic review
Mccallion, E. A., and B. W. Smith, "Reducing Anxiety & Depression Using Mindfulness-Based Stress Reduction in a Hispanic Primary Care Population," <i>Annals of Behavioral Medicine</i> , Vol. 47, Apr, 2014, pp. S21-S21. <Go to ISI>://WOS:000334408300078	Does not report data for MDD
McCarney, R., Schulz, J., and Grey, A. (2012). Effectiveness of mindfulness-based therapies in reducing symptoms of depression: A meta-analysis. <i>European Journal of Psychotherapy and Counselling</i> , 14(3), 279-299.	Systematic review
McMillan, T., Robertson, I. H., Brock, D., and Chorlton, L. (2002). Brief mindfulness training for attentional problems after traumatic brain injury: a randomised control treatment trial. <i>Neuropsychological Rehabilitation</i> , 12(2), 117-125. doi: 10.1080/09602010143000202	Does not report data for MDD
Mead, G. E., Morley, W., Campbell, P., Greig, C. A., McMurdo, M., and Lawlor, D. A. (2008). Exercise for depression. <i>Cochrane Database of Systematic Reviews</i> (4).	Systematic review
Meadows, G. N., F. Shawyer, J. C. Enticott, A. L. Graham, F. Judd, P. R. Martin, L. Piterman, and Z. Segal, "Mindfulness-Based Cognitive Therapy for Recurrent Depression: A Translational Research Study with 2-Year Follow-Up," <i>Aust N Z J Psychiatry</i> , Vol. 48, No. 8, Mar 4, 2014, pp. 743-755. http://anp.sagepub.com/content/48/8/743.full.pdf	Does not report data for MDD

Publication	Exclusion Reason
Mehta, P., and Sharma, M. (2010). Yoga as a complementary therapy for clinical depression. <i>Complementary Health Practice Review</i> , 15(3), 156-170. doi: 10.1177/1533210110387405	Systematic review
Melyani, M., A. A. Allahyari, P. A. Falah, A. F. Ashtiani, and A. Tavoli, (2015) "Mindfulness Based Cognitive Therapy Versus Cognitive Behavioral Therapy in Cognitive Reactivity and Self-Compassion in Females with Recurrent Depression with Residual Symptoms," <i>Journal of Psychology</i> , Vol. 18, No. 4, Win 2015, pp. 393-407. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2015-00242-004&site=ehost-live	Not RCT
Metcalfe, C. A., and S. Dimidjian, "Extensions and Mechanisms of Mindfulness-Based Cognitive Therapy: A Review of the Evidence," <i>Australian Psychologist</i> , Vol. 49, No. 5, Oct, 2014, pp. 271-279. <Go to ISI>://WOS:000341516300001 http://onlinelibrary.wiley.com/store/10.1111/ap.12074/asset/ap12074.pdf?v=1&t=i7gk0dqk&s=698524060664656b5c60927d72963cec4e1c5439	Nonsystematic review
Meyer, B., Berger, T., Caspar, F., Beevers, C. G., Andersson, G., and Weiss, M. (2009). Effectiveness of a novel integrative online treatment for depression (Deprexis): randomized controlled trial. <i>Journal of Medical Internet Research</i> , 11(2), e15. doi: 10.2196/jmir.1151	Does not report data for MDD
Meyer, H. B., Katsman, A., Sones, A. C., Auerbach, D. E., Ames, D., and Rubin, R. T. (2012). Yoga as an ancillary treatment for neurological and psychiatric disorders: a review. <i>Journal of Neuropsychiatry and Clinical Neurosciences</i> , 24(2), 152-164.	Systematic review
Michalak, J., Heidenreich, T., Meibert, P., and Schulte, D. (2008). Mindfulness predicts relapse/recurrence in major depressive disorder after mindfulness-based cognitive therapy. <i>Journal of Nervous and Mental Disease</i> , 196(8), 630-633. doi: 10.1097/NMD.0b013e31817d0546	Does not report relevant outcome data
J. Michalak, A. Holz and T. Teismann. (2011) Rumination as a predictor of relapse in mindfulness-based cognitive therapy for depression. <i>Psychology and Psychotherapy: Theory, Research and Practice</i> , 84, 230–236.	Not RCT
Michalak, J., Troje, N. F., and Heidenreich, T. (2011). The effects of mindfulness-based cognitive therapy on depressive gait patterns. <i>Journal of Cognitive and Behavioral Psychotherapies</i> . 11 (1) 13-27.	Not RCT
Michalsen, A., Grossman, P., Acil, A., Langhorst, J., Ludtke, R., Esch, T., Stefano, G., Dobos, G. J. (2005). Rapid stress reduction and anxiolysis among distressed women as a consequence of a three-month intensive yoga program. <i>Medical Science Monitor</i> , 11(12), CR555-561.	Does not report data for MDD
Michalsen, A., Grossman, P., Acil, A., Lüdtkke, R., Langhorst, J., and Dobos, G. J. (2005). Effects of 3 months intensified Iyengar yoga on emotional and physical well-being in women with mental distress. 12th Annual Symposium on Complementary Health Care -- Abstracts: 19th-21st September 2005, Exeter, UK. <i>Focus on Alternative and Complementary Therapies</i> , 10, 37-37.	Conference proceeding
Michalsen, A., Jeitler, M., Brunnhuber, S., Ludtke, R., Bussing, A., Musial, F., Dobos, G., and Kessler, C. (2012). Iyengar yoga for distressed women: a 3-armed randomized controlled trial. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2012, 408727. doi: 10.1155/2012/408727	Does not report data for MDD

Publication	Exclusion Reason
Michalsen, A., Traiteur, H., Ludtke, R., Brunnhuber, S., Meier, L., Jeitler, M., Büssing, A., and Kessler, C. (2012). Yoga for chronic neck pain: a pilot randomized controlled clinical trial. <i>Journal of Pain</i> , 13(11), 1122-1130. doi: 10.1016/j.jpain.2012.08.004	Does not report data for MDD
Milbury, K., Chaoul, A., Biegler, K., Wangyal, T., Spelman, A., Meyers, C. A., Arun, B., Palmer, J. L., Taylor, J., Cohen, L. (2013). Tibetan sound meditation for cognitive dysfunction: results of a randomized controlled pilot trial. <i>Psychooncology</i> . doi: 10.1002/pon.3296	Does not report data for MDD
Miller, J. J., Fletcher, K., and Kabat-Zinn, J. (1995). Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. <i>General Hospital Psychiatry</i> , 17(3), 192-200.	Does not report data for MDD
Miller, J. H. (2012). Does the evidence that mindfulness-based interventions may assist counsellors and their clients post-earthquake stack up? <i>Counselling Psychology Quarterly</i> , 25(3), 339-342. doi: 10.1080/09515070.2012.672257	Does not report data for MDD
Mindfulness may prevent depression recurring. (2012). <i>Occupational Health</i> , 64(10), 4-4.	Background
Mishra, M., and Kumar, S. R. (2001). Effect of yogic practices on depression and anxiety. <i>Journal of Projective Psychology and Mental Health</i> , 8(1), 23-27.	Does not report data for MDD
Mishra, S. I., Scherer, R. W., Snyder, C., Geigle, P. M., Berlanstein, D. R., and Topaloglu, O. (2012). Exercise interventions on health-related quality of life for people with cancer during active treatment. <i>Cochrane Database of Systematic Reviews (CDSR)</i> , 8, CD008465. doi: 10.1002/14651858.CD008465.pub2	Does not report data for meditation for MDD
Moody, K., Kramer, D., Santizo, R. O., Magro, L., Wyshogrod, D., Ambrosio, J., Castillo, C., Lieberman, R., and Stein, J. (2013). Helping the helpers: mindfulness training for burnout in pediatric oncology--a pilot program. <i>Journal of Pediatric Oncology Nursing</i> , 30(5), 275-284. doi: 10.1177/1043454213504497	Does not report data for MDD
Moritz, S., and Rufer, M. (2011). Movement decoupling: A self-help intervention for the treatment of trichotillomania. <i>Journal of Behavior Therapy and Experimental Psychiatry</i> , 42(1), 74-80. doi: 10.1016/j.jbtep.2010.07.001	Does not report data for MDD
Morriss, R. K., and Scott, J. (2009). Psychological management of mood disorders. <i>Psychiatry</i> , 8(4), 108-112.	Nonsystematic review
Moynihan, J. A., Chapman, B. P., Klorman, R., Krasner, M. S., Duberstein, P. R., Brown, K. W., and Talbot, N. L. (2013). Mindfulness-based stress reduction for older adults: effects on executive function, frontal alpha asymmetry and immune function. <i>Neuropsychobiology</i> , 68(1), 34-43. doi: 10.1159/000350949	Does not report data for MDD
Murthy, P. J. Naga Venkatesha, Janakiramaiah, N., Gangadhar, B. N., and Subbakrishna, D. K. (1998). P300 amplitude and antidepressant response to Sudarshan Kriya Yoga (SKY). <i>Journal of Affective Disorders</i> , 50(1), 45-48. doi: 10.1016/S0165-0327(98)00029-9	Does not report data for MDD
Muzik, M., Hamilton, S. E., Lisa Rosenblum, K., Waxler, E., and Hadi, Z. (2012). Mindfulness yoga during pregnancy for psychiatrically at-risk women: preliminary results from a pilot feasibility study. <i>Complementary Therapies in Clinical Practice</i> , 18(4), 235-240. doi: 10.1016/j.ctcp.2012.06.006	Does not report data for MDD
Nakamura, Y., Lipschitz, D. L., Kuhn, R., Kinney, A. Y., and Donaldson, G. W. (2013). Investigating efficacy of two brief mind-body intervention programs for managing sleep disturbance in cancer survivors: a pilot randomized controlled trial. <i>Journal of Cancer Survivorship</i> , 7(2), 165-182. doi: 10.1007/s11764-012-0252-8	Does not report data for MDD

Publication	Exclusion Reason
Nakamura, Y., Lipschitz, D. L., Landward, R., Kuhn, R., and West, G. (2011). Two sessions of sleep-focused mind-body bridging improve self-reported symptoms of sleep and PTSD in veterans: A pilot randomized controlled trial. <i>Journal of Psychosomatic Research</i> , 70(4), 335-345. doi: 10.1016/j.jpsychores.2010.09.007	Does not report data for MDD
Naveen, G. H., Rao, M. G., Vishal, V., Thirthalli, J., Varambally, S., and Gangadhar, B. N. (2013). Development and feasibility of yoga therapy module for out-patients with depression in India. <i>Indian Journal of Psychiatry</i> , 55(Suppl 3), S350-356. doi: 10.4103/0019-5545.116305	Case report
Naveen, G. H., Thirthalli, J., Rao, M. G., Varambally, S., Christopher, R., and Gangadhar, B. N. (2013). Positive therapeutic and neurotropic effects of yoga in depression: A comparative study. <i>Indian Journal of Psychiatry</i> , 55(Suppl 3), S400-404. doi: 10.4103/0019-5545.116313	Does not report data for MDD
Neece, C. L. (2013). Mindfulness-Based Stress Reduction for Parents of Young Children with Developmental Delays: Implications for Parental Mental Health and Child Behavior Problems. <i>Journal of Applied Research in Intellectual Disabilities</i> . doi: 10.1111/jar.12064	Does not report data for MDD
Netz, Y., and Lidor, R. (2003). Mood alterations in mindful versus aerobic exercise modes. <i>Journal of Psychology</i> , 137(5), 405-419. doi: 10.1080/00223980309600624	Does not report data for MDD
Nickels, M. W., Privitera, M. R., Coletta, M., and Sullivan, P. (2009). Treating depression: psychiatric consultation in cardiology. <i>Cardiology Journal</i> , 16(3), 279-293.	Nonsystematic review
Nidich, S. I., Rainforth, M. V., Haaga, D. A., Hagelin, J., Salerno, J. W., Travis, F., Tanner, M., Gaylord-King, C., Grosswald, S., and Schneider, R. H. (2009). A randomized controlled trial on effects of the Transcendental Meditation program on blood pressure, psychological distress, and coping in young adults. <i>American Journal of Hypertension</i> , 22(12), 1326-1331. doi: 10.1038/ajh.2009.184	Does not report data for MDD
Noonan, S., (2014) "Mindfulness-Based Stress Reduction," <i>Can Vet J</i> , 55 (2): 134-135.	Background
Nyer, M., Doorley, J., Durham, K., Yeung, A. S., Freeman, M. P., and Mischoulon, D. (2013). What is the Role of Alternative Treatments in Late-life Depression? <i>Psychiatric Clinics of North America</i> , 36(4), 577-596. doi: 10.1016/j.psc.2013.08.012	Nonsystematic review
Nyklicek, I., Dijkman, S. C., Lenders, P. J., Fonteijn, W. A., and Koolen, J. J. (2012). A brief mindfulness based intervention for increase in emotional well-being and quality of life in percutaneous coronary intervention (PCI) patients: the MindfulHeart randomized controlled trial. <i>Journal of Behavioral Medicine</i> . doi: 10.1007/s10865-012-9475-4	Does not report data for MDD
O'Connor, Maja, Piet, Jacob, and Hougaard, Esben. (2013). The effects of mindfulness-based cognitive therapy on depressive symptoms in elderly bereaved people with loss-related distress: A controlled pilot study. <i>Mindfulness</i> . doi: 10.1007/s12671-013-0194-x	Does not report data for MDD
O'Doherty, V., Carr, A., Kehoe, A., and Graham, I. (2009). Evaluating mindfulness based cognitive behavioural group intervention for patients with coronary heart disease and depression. <i>Psychology and Health</i> , 24, 294-294.	Conference proceeding
O'Doherty, V., A. Carr, A. McGrann, J. O. O'Neill, S. Dinan, I. Graham, and V. Maher, (2014) "A Controlled Evaluation of Mindfulness-Based Cognitive Therapy for Patients with Coronary Heart Disease and Depression," <i>Mindfulness</i> . http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2014-01236-001&site=ehost-live http://download.springer.com/static/pdf/51/art%253A10.1007%252Fs12671-013-0272-	Not RCT

Publication	Exclusion Reason
0.pdf?auth66=1426794468_c4a4c715a47d6e2d4b6658a153e5a2c6&ext=.pdf	
Oh, B., Choi, S. M., Inamori, A., Rosenthal, D., and Yeung, A. (2013). Effects of qigong on depression: a systemic review. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 134737. doi: 10.1155/2013/134737	Systematic review
Olivo, E. L., Dodson-Lavelle, B., Wren, A., Fang, Y., and Oz, M. C. (2009). Feasibility and effectiveness of a brief meditation-based stress management intervention for patients diagnosed with or at risk for coronary heart disease: a pilot study. <i>Psychology Health & Medicine</i> , 14(5), 513-523. doi: 10.1080/13548500902890087	Does not report data for MDD
Omidi, A., Mohammakhani, P., Poorshahbaz, A., and Dolatshahi, B. (2009). Efficiency of combined mindfulness based cognitive therapy with cognitive behavior therapy in major depressive disorder. <i>Psychology and Health</i> , 24, 297-297.	Conference proceeding
Omidi, A., Sazvar, S. A., Akbari, H., and Heidarinasab, L. (2010). Efficacy of combined mindfulness based cognitive therapy with CBT and traditional cognitive behaviour therapy in reduction of global severity index (GSI) of patients with major depressive disorder. <i>Psychology and Health</i> , 25, 292-292.	Conference proceeding
Ost, L. G., and Breitholtz, E. (2000). Applied relaxation vs. cognitive therapy in the treatment of generalized anxiety disorder. <i>Behaviour Research and Therapy</i> , 38(8), 777-790. doi: 10.1016/s0005-7967(99)00095-9	Does not report data for MDD
Overcash, J., Will, K. M., and Lipetz, D. W. (2013). The benefits of medical qigong in patients with cancer: a descriptive pilot study. <i>Clinical Journal of Oncology Nursing</i> , 17(6), 654-658. doi: 10.1188/13.cjon.654-658	Does not report data for MDD
Pagnini, F., C. Di Credico, R. Gatto, V. Fabiani, G. Rossi, C. Lunetta, A. Marconi, F. Fossati, G. Castelnuovo, A. Tagliaferri, P. Banfi, M. Corbo, V. Sansone, E. Molinari, and G. Amadei, "Meditation Training for People with Amyotrophic Lateral Sclerosis and Their Caregivers," <i>Journal of Alternative and Complementary Medicine</i> , Vol. 20, No. 4, Apr, 2014, pp. 272-275. <Go to ISI>://WOS:000338347200008 http://online.liebertpub.com/doi/abs/10.1089/acm.2013.0268	Not RCT
Paluska, S. A., and Schwenk, T. L. (2000). Physical activity and mental health: current concepts. <i>Sports Medicine</i> , 29(3), 167-180.	Does not report data for meditation for MDD
Pandey, S., Mahato, N. K., and Navale, R. (2010). Role of self-induced sound therapy: Bhramari Pranayama in Tinnitus. <i>Audiological Medicine</i> , 8(3), 137-141.	Does not report data for MDD
Parikh, S. V., Segal, Z. V., Grigoriadis, S., Ravindran, A. V., Kennedy, S. H., Lam, R. W., and Patten, S. B. (2009). Canadian Network for Mood and Anxiety Treatments (CANMAT) clinical guidelines for the management of major depressive disorder in adults. II. Psychotherapy alone or in combination with antidepressant medication. <i>Journal of Affective Disorders</i> , 117 Suppl 1, S15-25. doi: 10.1016/j.jad.2009.06.042	Systematic review
Park, J., and McCaffrey, R. (2012). Chair yoga: benefits for community-dwelling older adults with osteoarthritis. <i>Journal of Gerontological Nursing</i> , 38(5), 12-22; quiz 24-15. doi: 10.3928/00989134-20120410-01	Does not report data for MDD
Parra-Delgado, M., and Latorre-Postigo, J. M. (2013). Effectiveness of mindfulness-based cognitive therapy in the treatment of fibromyalgia: a randomised trial. <i>Cognitive Therapy and Research</i> , 37(5), 1015-1026. doi: 10.1007/s10608-013-9538-z	Does not report data for MDD

Publication	Exclusion Reason
Parswani, M. J., Sharma, M. P., and Iyengar, S. (2013). Mindfulness-based stress reduction program in coronary heart disease: A randomized control trial. <i>International Journal of Yoga (IJoY)</i> , 6(2), 111-117. doi: 10.4103/0973-6131.113405	Does not report data for MDD
Patel, N. K., Newstead, A. H., and Ferrer, R. L. (2012). The effects of yoga on physical functioning and health related quality of life in older adults: a systematic review and meta-analysis. <i>Journal of Alternative and Complementary Medicine</i> , 18(10), 902-917. doi: 10.1089/acm.2011.0473	Systematic review
Paul, N. A., Stanton, S. J., Greeson, J. M., Smoski, M. J., and Wang, L. (2013). Psychological and neural mechanisms of trait mindfulness in reducing depression vulnerability. <i>Social Cognitive and Affective Neuroscience</i> , 8(1), 56-64. doi: 10.1093/scan/nss070	Does not report data for MDD
Paulik, G., Simcocks, A., Weiss, L., and Albert, S. (2010). Benefits of a 12-week mindfulness group program for mental health consumers in an outpatient setting. <i>Mindfulness</i> , 1(4), 215-226. doi: 10.1007/s12671-010-0030-5	Does not report data for MDD
Payne, H. (2009). The BodyMind Approach (BMA) to psychotherapeutic groupwork with patients with medically unexplained symptoms (MUS): A review of the literature, description of approach and methodology for a pilot study. <i>European Journal of Psychotherapy and Counselling</i> , 11(3), 287-310. doi: 10.1080/13642530903230392	Systematic review
Payne, P., and Crane-Godreau, M. A. (2013). Meditative movement for depression and anxiety. <i>Frontiers in Psychiatry</i> , 4(JUL).	Systematic review
Peeke, P. M., and Frishett, S. (2002). The role of complementary and alternative therapies in women's mental health. <i>Primary Care - Clinics in Office Practice</i> , 29(1), 183-197.	Nonsystematic review
Perelman, A. M., Miller, S. L., Clements, C. B., Rodriguez, A., Allen, K., and Cavanaugh, R. (2012). Meditation in a deep South prison: a longitudinal study of the effects of Vipassana. <i>Journal of Offender Rehabilitation</i> , 51(3), 176-198. doi: 10.1080/10509674.2011.632814	Does not report data for MDD
Persson, A. L., Veenhuizen, H., Zachrisson, L., and Gard, G. (2008). Relaxation as treatment for chronic musculoskeletal pain -- a systematic review of randomised controlled studies. <i>Physical Therapy Reviews</i> , 13(5), 355-365.	Systematic review
Piet, J., and Hougaard, E. (2011). The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: a systematic review and meta-analysis. <i>Clinical Psychology Review</i> , 31(6), 1032-1040. doi: 10.1016/j.cpr.2011.05.002	Systematic review
Piet, J., Wurtzen, H., and Zachariae, R. (2012). The effect of mindfulness-based therapy on symptoms of anxiety and depression in adult cancer patients and survivors: a systematic review and meta-analysis. <i>Journal of Consulting and Clinical Psychology</i> , 80(6), 1007-1020. doi: 10.1037/a0028329	Systematic review
Pilkington, K., Kirkwood, G., Rampes, H., and Richardson, J. (2005). Yoga for depression: the research evidence. <i>Journal of Affective Disorders</i> , 89(1-3), 13-24. doi: 10.1016/j.jad.2005.08.013	Systematic review
Pilkington, K., Rampes, H., and Richardson, J. (2006). Complementary medicine for depression. <i>Expert Review Neurotherapeutics</i> , 6(11), 1741-1751. doi: 10.1586/14737175.6.11.1741	Nonsystematic review
Pineda, M. J., and Singh, D. K. (2012). What is integrative oncology and can it help my patients? <i>Obstetrics and Gynecology Clinics of North America</i> , 39(2), 285-312.	Does not report data for meditation for

Publication	Exclusion Reason
	MDD
Pinniger, R., Brown, R. F., Thorsteinsson, E. B., and McKinley, P. (2012). Argentine tango dance compared to mindfulness meditation and a waiting-list control: a randomised trial for treating depression. <i>Complementary Therapies in Medicine</i> , 20(6), 377-384. doi: 10.1016/j.ctim.2012.07.003	Does not report data for meditation for MDD
Pinniger, R., Thorsteinsson, E. B., Brown, R. F., and McKinley, P. (2013). Tango dance can reduce distress and insomnia in people with self-referred affective symptoms. <i>American Journal of Dance Therapy</i> , 35(1), 60-77. doi: 10.1007/s10465-012-9141-y	Does not report data for MDD
Pipe, T. B., Bortz, J. J., Dueck, A., Pendergast, D., Buchda, V., and Summers, J. (2009). Nurse leader mindfulness meditation program for stress management: a randomized controlled trial. <i>Journal of Nursing Administration</i> , 39(3), 130-137. doi: 10.1097/NNA.0b013e31819894a0	Does not report data for MDD
Posadzki, P. (2011). Tai Chi/Qigong improves selected indicators of metabolic syndrome, QoL, depression and perceived stress. <i>Focus on Alternative and Complementary Therapies</i> , 16(2), 161-162. doi: 10.1111/j.2042-7166.2011.01091	Does not report data for MDD
Posadzki, P. (2013). Tai Chi chih improves inflammatory markers, cognition and quality of life scores in elderly depressed patients. <i>Focus on Alternative and Complementary Therapies</i> , 18(1), 39-40. doi: 10.1111/ftc.12009	Background
Pots, W. T., P. A. Meulenbeek, M. M. Veehof, J. Klungers, and E. T. Bohlmeijer, (2014) "The Efficacy of Mindfulness-Based Cognitive Therapy as a Public Mental Health Intervention for Adults with Mild to Moderate Depressive Symptomatology: A Randomized Controlled Trial," <i>PLoS One</i> , Vol. 9, No. 10, p. e109789.	Does not report data for MDD
Pradhan, E. K., Baumgarten, M., Langenberg, P., Handwerger, B., Gilpin, A. K., Magyari, T., Hochberg, M C., and Berman, B. M. (2007). Effect of Mindfulness-Based Stress Reduction in rheumatoid arthritis patients. <i>Arthritis & Rheumatology</i> , 57(7), 1134-1142. doi: 10.1002/art.23010	Does not report data for MDD
Prakhinkit, S., Suppakitiporn, S., Tanaka, H., and Suksom, D. (2014). "Effects of buddhism walking meditation on depression, functional fitness, and endothelium-dependent vasodilation in depressed elderly," <i>Journal of Alternative and Complementary Medicine</i> , 20 (5), 411-416.	Does not report data for MDD
Price, C. J., Wells, E. A., Donovan, D. M., and Rue, T. (2012). Mindful awareness in body-oriented therapy as an adjunct to women's substance use disorder treatment: a pilot feasibility study. <i>Journal of Substance Abuse Treatment</i> , 43(1), 94-107. doi: 10.1016/j.jsat.2011.09.016	Does not report data for MDD
Putiri, A. L., Lovejoy, J. C., Gillham, S., Sasagawa, M., Bradley, R., and Sun, G. C. (2012). Psychological effects of Yi Ren Medical Qigong and progressive resistance training in adults with type 2 diabetes mellitus: a randomized controlled pilot study. <i>Alternative Therapies In Health And Medicine</i> , 18(1), 30-34.	Does not report data for MDD
Quick, M., and Kiefer, D. (2013). Qigong reduces depression in women with breast cancer receiving radiotherapy. <i>Integrative Medicine Alert</i> , 16(5), 54-57.	Does not report data for MDD
Qureshi, N. A., and Al-Bedah, A. M. (2013). Mood disorders and complementary and alternative medicine: a literature review. <i>Neuropsychiatric Disease and Treatment</i> , 9, 639-658. doi: 10.2147/ndt.s43419	Systematic review
Radford, S. R., Crane, R. S., Eames, C., Gold, E., and Owens, G. W. (2012). The feasibility and effectiveness of mindfulness-based cognitive therapy for mixed diagnosis patients in primary care: a pilot study. <i>Mental Health in Family Medicine</i> , 9(3), 191-200.	Does not report data for MDD

Publication	Exclusion Reason
Raes, F., Dewulf, D., Van Heeringen, C., and Williams, J. M. (2009). Mindfulness and reduced cognitive reactivity to sad mood: evidence from a correlational study and a non-randomized waiting list controlled study. <i>Behaviour Research and Therapy</i> , 47(7), 623-627. doi: 10.1016/j.brat.2009.03.007	Does not report data for MDD
Raghavendra, R. M., Nagarathna, R., Nagendra, H. R., Gopinath, K. S., Srinath, B. S., Ravi, B. D., Patil, S., Ramesh, B. S. and Nalini, R. (2007). Effects of an integrated yoga programme on chemotherapy-induced nausea and emesis in breast cancer patients. <i>European Journal of Cancer Care (Engl)</i> , 16(6), 462-474. doi: 10.1111/j.1365-2354.2006.00739.x	Does not report data for MDD
Raghavendra, R. M., Vadiraja, H. S., Nagarathna, R., Nagendra, H. R., Rekha, M., Vanitha, N., Gopinath, K.S., Srinath, B. S., Vishweshwara, M. S., Madhavi, Y. S., Ajaikumar, B. S.,	Does not report data for MDD
Ramel, W., Goldin, P. R., Carmona, P. E. and McQuaid, J. R. (2004). The effects of mindfulness meditation on cognitive processes and affect in patients with past depression. <i>Cognitive Therapy and Research</i> , 28 (4): 433–455.	Not RCT
Ramesh, B. S., Nalini, R. and Kumar, V. (2009). Effects of a yoga program on cortisol rhythm and mood states in early breast cancer patients undergoing adjuvant radiotherapy: a randomized controlled trial. <i>Integrative Cancer Therapies</i> , 8(1), 37-46. doi: 10.1177/1534735409331456	Does not report data for MDD
Raison, C. L. (2008). Buddhists meet mind scientists in conference on meditation and depression. <i>Psychiatric Times</i> , 25(3), 12-13.	Conference Proceeding
Ramachandra, P., Booth, S., Pieters, T., Vrotsou, K., and Huppert, F. A. (2009). A brief self-administered psychological intervention to improve well-being in patients with cancer: results from a feasibility study. <i>Psychooncology</i> , 18(12), 1323-1326. doi: 10.1002/pon.1516	Does not report data for MDD
Rani, N. Jhansi, and Rao, P. V. Krishna. (2005). Impact of yoga training on body image and depression. <i>Psychological Studies</i> , 50(1), 98-100.	Does not report data for MDD
Rao, N. P., Varambally, S., and Gangadhar, B. N. (2013). Yoga school of thought and psychiatry: Therapeutic potential. <i>Indian Journal of Psychiatry</i> , 55(Suppl 2), S145-149. doi: 10.4103/0019-5545.105510	Nonsystematic review
Rao, R. M., Nagendra, H. R., Raghuram, N., Vinay, C., Chandrashekara, S., Gopinath, K. S., and Srinath, B. S. (2008). Influence of yoga on mood states, distress, quality of life and immune outcomes in early stage breast cancer patients undergoing surgery. <i>International Journal of Yoga (IJoY)</i> , 1(1), 11-20. doi: 10.4103/0973-6131.36789	Does not report data for MDD
Ravindran, A. V., and da Silva, T. L. (2013). Complementary and alternative therapies as add-on to pharmacotherapy for mood and anxiety disorders: a systematic review. <i>Journal of Affective Disorders</i> , 150(3), 707-719. doi: 10.1016/j.jad.2013.05.042	Systematic review
Ravindran, A. V., Lam, R. W., Filteau, M. J., Lesperance, F., Kennedy, S. H., Parikh, S. V., and Patten, S. B. (2009). Canadian Network for Mood and Anxiety Treatments (CANMAT) clinical guidelines for the management of major depressive disorder in adults. V. Complementary and alternative medicine treatments. <i>Journal of Affective Disorders</i> , 117 Suppl 1, S54-64. doi: 10.1016/j.jad.2009.06.040	Systematic review
Ray, U. S., Mukhopadhyaya, S., Purkayastha, S. S., Asnani, V., Tomer, O. S., Prashad, R., Thakur, L., and Selvamurthy, W. (2001). Effect of yogic exercises on physical and mental health of young fellowship course trainees. <i>Indian Journal of Physiology and Pharmacology</i> , 45(1), 37-53.	Does not report data for MDD

Publication	Exclusion Reason
Redwine, L. S., Tsuang, M., Rusiewicz, A., Pandzic, I., Cammarata, S., Rutledge, T., Hong, S., Linke, S. and Mills, P. J. (2012). A pilot study exploring the effects of a 12-week T'ai Chi intervention on somatic symptoms of depression in patients with heart failure. <i>Journal of Alternative and Complementary Medicine</i> , 18(8), 744-748.	Does not report data for MDD
Redwine, L. S., M. S. Pung, S. S. Hong, K. S. Wilson, K. S. Chinh, F. S. Iqbal, and P. J. Mills, "Tai Chi Intervention May Lead to Improved Cognitive Function Associated with Reduced Depression Symptoms in Heart Failure Patients," <i>Psychosomatic Medicine</i> , Vol. 76, No. 3, Apr, 2014, pp. A51-A51. <Go to ISI>://WOS:000334235100215	Does not report data for MDD
Regehr, C., Glancy, D., and Pitts, A. (2013). Interventions to reduce stress in university students: a review and meta-analysis. <i>Journal of Affective Disorders</i> , 148(1), 1-11. doi: 10.1016/j.jad.2012.11.026	Systematic review
Reibel, D. K., Greeson, J. M., Brainard, G. C., and Rosenzweig, S. (2001). Mindfulness-based stress reduction and health-related quality of life in a heterogeneous patient population. <i>General Hospital Psychiatry</i> , 23(4), 183-192.	Does not report data for MDD
Rimes, K. A., and Wingrove, J. (2013). Mindfulness-based cognitive therapy for people with chronic fatigue syndrome still experiencing excessive fatigue after cognitive behaviour therapy: a pilot randomized study. <i>Clinical Psychology & Psychotherapy</i> , 20(2), 107-117. doi: 10.1002/cpp.793	Does not report data for MDD
Rizvi, S. L., and L. M. Steffel, "A Pilot Study of 2 Brief Forms of Dialectical Behavior Therapy Skills Training for Emotion Dysregulation in College Students," <i>Journal of American College Health</i> , Vol. 62, No. 6, 2014, pp. 434-439. <Go to ISI>://WOS:000342294900010 http://www.tandfonline.com/doi/pdf/10.1080/07448481.2014.907298	Does not report data for MDD
Roberts-Wolfe, D., Sacchet, M. D., Hastings, E., Roth, H., and Britton, W. (2012). Mindfulness training alters emotional memory recall compared to active controls: support for an emotional information processing model of mindfulness. <i>Frontiers in Human Neuroscience</i> , 6, 15. doi: 10.3389/fnhum.2012.00015	Does not report data for MDD
Rodin, G., Lloyd, N., Katz, M., Green, E., Mackay, J. A., and Wong, R. K. (2007). The treatment of depression in cancer patients: a systematic review. <i>Support Care Cancer</i> , 15(2), 123-136. doi: 10.1007/s00520-006-0145-3	Systematic review
Rodriguez Vega, B., Bayon Perez, C., Palaotarrero, A., and Fernandez Liria, A. (2013). Mindfulness-based narrative therapy for depression in cancer patients. <i>Clinical Psychology & Psychotherapy</i> . doi: 10.1002/cpp.1847	Nonsystematic review
Roeser, R. W., Schonert-Reichl, K. A., Jha, A., Cullen, M., Wallace, L., Wilensky, R., . . . Harrison, J. (2013). Mindfulness training and reductions in teacher stress and burnout: results from two randomized, waitlist-control field trials. <i>Journal of Educational Psychology</i> , 105(3), 787-804. doi: 10.1037/a0032093	Does not report data for MDD
Rogers, C. E., Larkey, L. K., and Keller, C. (2009). A review of clinical trials of Tai Chi and Qigong in older adults. <i>West Journal of Nursing Research</i> , 31(2), 245-279. doi: 10.1177/0193945908327529	Systematic review
Rogojanski, J., Vettese, L. C., and Martin, A. M. (2011). Coping with cigarette cravings: comparison of suppression versus mindfulness-based strategies. <i>Mindfulness</i> , 2(1), 14-26. doi: 10.1007/s12671-010-0038-x	Does not report data for MDD
Rohini, V., Pandey, R. S., Janakiramaiah, N., Gangadhar, B. N., and Vedamurthachar, A. (2000). A comparative study of full and partial Sudarshan Kriya Yoga (SKY) in major depressive disorder. <i>NIMHANS Journal</i> , 18(1-2), 53-57.	Not MBCT

Publication	Exclusion Reason
Rohsenow, D. J., Monti, P. M., Martin, R. A., Michalec, E., and Abrams, D. B. (2000). Brief coping skills treatment for cocaine abuse: 12-month substance use outcomes. <i>Journal of Consulting and Clinical Psychology</i> , 68(3), 515-520.	Does not report data for MDD
Rohsenow, D. J., Smith, R. E., and Johnson, S. (1985). Stress management training as a prevention program for heavy social drinkers: cognitions, affect, drinking, and individual differences. <i>Addictive Behaviors</i> , 10(1), 45-54.	Does not report data for MDD
Romero-Zurita, A., Carbonell-Baeza, A., Aparicio, V. A., Ruiz, J. R., Tercedor, P., and Delgado-Fernandez, M. (2012). Effectiveness of a tai-chi training and detraining on functional capacity, symptomatology and psychological outcomes in women with fibromyalgia. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2012, 614196. doi: 10.1155/2012/614196	Does not report data for MDD
Rosenbaum, S., A. Tiedemann, C. Sherrington, J. Curtis, and P. B. Ward, "Physical Activity Interventions for People with Mental Illness: A Systematic Review and Meta-Analysis," <i>J Clin Psychiatry</i> , Vol. 75, No. 9, Sep, 2014, pp. 964-974.	Systematic review
Rosmarin, D. H., Pargament, K. I., Pirutinsky, S., and Mahoney, A. (2010). A randomized controlled evaluation of a spiritually integrated treatment for subclinical anxiety in the Jewish community, delivered via the Internet. <i>Journal of Anxiety Disorders</i> , 24(7), 799-808. doi: 10.1016/j.janxdis.2010.05.014	Does not report data for MDD
Ross, A., and Thomas, S. (2010). The Health Benefits of Yoga and Exercise: A Review of Comparison Studies. <i>Journal of Alternative and Complementary Medicine</i> , 16(1), 3-12. doi: 10.1089/acm.2009.0044	Systematic review
Rubia, K. (2009). The neurobiology of meditation and its clinical effectiveness in psychiatric disorders. <i>Biological Psychology</i> , 82(1), 1-11. doi: 10.1016/j.biopsycho.2009.04.003	Nonsystematic review
Rungreangkulkij, S., Wongtakee, W., and Thongyot, S. (2011). Buddhist group therapy for diabetes patients with depressive symptoms. <i>Archives of Psychiatric Nursing</i> , 25(3), 195-205. doi: 10.1016/j.apnu.2010.08.007	Does not report data for MDD
Sachse, S., Keville, S., and Feigenbaum, J. (2011). A feasibility study of mindfulness-based cognitive therapy for individuals with borderline personality disorder. <i>Psychology and Psychotherapy: Theory, Research and Practice</i> , 84(2), 184-200. doi: 10.1348/147608310x516387	Does not report data for MDD
Saeed, S. A., Antonacci, D. J., and Bloch, R. M. (2010). Exercise, yoga, and meditation for depressive and anxiety disorders. <i>American Family Physician</i> , 81(8), 981-986.	Nonsystematic review
Sagula, D., and Rice, K. G. (2004). The effectiveness of mindfulness training on the grieving process and emotional well-being of chronic pain patients. <i>Journal of Clinical Psychology in Medical Settings</i> , 11(4), 333-342. doi: 10.1023/b:jocs.0000045353.78755.51	Does not report data for MDD
Sahdra, B. K., MacLean, K. A., Ferrer, E., Shaver, P. R., Rosenberg, E. L., Jacobs, T. L., Zanesco, A. P., King, B. G., Aichele, S. R., Bridwell, D. A., Mangun, G. R., Lavy, S., Alan, W. B. and Saron, C. D. (2011). Enhanced response inhibition during intensive meditation training predicts improvements in self-reported adaptive socioemotional functioning. <i>Emotion</i> , 11(2), 299-312. doi: 10.1037/a0022764	Does not report data for MDD

Publication	Exclusion Reason
Salgado, B. C., Jones, M., Ilgun, S., McCord, G., Loper-Powers, M., and van Houten, P. (2013). Effects of a 4-month Ananda Yoga Program on physical and mental health outcomes for persons with multiple sclerosis. <i>International Journal of Yoga (IJoY) Therap</i> , 23(2), 27-38.	Does not report data for MDD
Salmoirago-Blotcher, E., Crawford, S. L., Carmody, J., Rosenthal, L., Yeh, G., Stanley, M., Rose, K., Browning, C. and Ockene, I. S. (2013). Phone-delivered mindfulness training for patients with implantable cardioverter defibrillators: results of a pilot randomized controlled trial. <i>Annals of Behavioral Medicine</i> , 46(2), 243-250. doi: 10.1007/s12160-013-9505-7	Does not report data for MDD
Salmon, P., Sephton, S., Weissbecker, I., Hoover, K., Ulmer, C., and Studts, J. L. (2004). Mindfulness meditation in clinical practice. <i>Cognitive and Behavioral Practice</i> , 11(4), 434-446. doi: 10.1016/s1077-7229(04)80060-9	Nonsystematic review
Santana, M. J., Julia, S., Parrilla, J. M., Loadman, M. A., Lien, D. C., and Feeny, D. (2013). An assessment of the effects of Iyengar yoga practice on the health-related quality of life of patients with chronic respiratory diseases: a pilot study. <i>Canadian Respiratory Journal</i> , 20(2), e17-23.	Does not report data for MDD
Sarubin, N., C. Nothdurfter, C. Schule, M. Lieb, M. Uhr, C. Born, R. Zimmermann, M. Buhner, K. Konopka, R. Rupprecht, and T. C. Baghai, "The Influence of Hatha Yoga as an Add-on Treatment in Major Depression on Hypothalamic-Pituitary-Adrenal-Axis Activity: A Randomized Trial," <i>J Psychiatr Res</i> , Vol. 53, Jun, 2014, pp. 76-83. http://ac.els-cdn.com/S0022395614000727/1-s2.0-S0022395614000727-main.pdf?_tid=0a37114e-ce6e-11e4-acc4-00000aabb0f6b&acdnat=1426793454_3b89e883dc02283088db37d6dc73a312	Not MBCT
Sattin, R. W., Easley, K. A., Wolf, S. L., Chen, Y., and Kutner, M. H. (2005). Reduction in fear of falling through intense Tai Chi exercise training in older, transitionally frail adults. <i>Journal of the American Geriatrics Society</i> , 53(7), 1168-1178. doi: 10.1111/j.1532-5415.2005.53375.x	Does not report data for MDD
Satyapriya, M., Nagarathna, R., Padmalatha, V., and Nagendra, H. R. (2013). Effect of integrated yoga on anxiety, depression and well being in normal pregnancy. <i>Complementary Therapies in Clinical Practice</i> , 19(4), 230-236. doi: 10.1016/j.ctcp.2013.06.003	Does not report data for MDD
Schaff, T. R. (2012). Senior yoga in and out of chairs. <i>Topics in Geriatric Rehabilitation</i> , 28(3), 223-237. doi: 10.1097/TGR.0b013e3182610204	Does not report data for MDD
Schmidt, S., Grossman, P., Schwarzer, B., Jena, S., Naumann, J., and Walach, H. (2011). Treating fibromyalgia with mindfulness-based stress reduction: results from a 3-armed randomized controlled trial. <i>Pain</i> , 152(2), 361-369. doi: 10.1016/j.pain.2010.10.043	Does not report data for MDD
Schmitz-Hubsch, T., Pyfer, D., Kielwein, K., Fimmers, R., Klockgether, T., and Wullner, U. (2006). Qigong exercise for the symptoms of Parkinson's disease: a randomized, controlled pilot study. <i>Movement Disorders</i> , 21(4), 543-548. doi: 10.1002/mds.20705	Does not report data for MDD
Schnare, S. M. (2000). Complementary and alternative medicine: A primer. <i>Clinical Obstetrics and Gynecology</i> , 43(1), 157-161.	Background or commentary
Schoenberg, P. L., and A. E. Speckens, "Modulation of Induced Frontocentral Theta (Fm-Theta) Event-Related (De-)Synchronisation Dynamics Following Mindfulness-Based Cognitive Therapy in Major Depressive Disorder," <i>Cogn Neurodyn</i> , Vol. 8, No. 5, Oct, 2014, pp. 373-388. http://download.springer.com/static/pdf/75/art%253A10.1007%252Fs11571-014-9294-0.pdf?auth66=1426794476_ea796d8fd362c4ecb751ebabf17d86ed&ext=.pdf	Not RCT

Publication	Exclusion Reason
Schoenberg, P. L. A., and A. E. M. Speckens, "Multi-Dimensional Modulations of Alpha and Gamma Cortical Dynamics Following Mindfulness-Based Cognitive Therapy in Major Depressive Disorder," <i>Cognitive Neurodynamics</i> , Vol. 9, No. 1, Feb, 2015, pp. 13-29. <Go to ISI>://WOS:000348373800002 http://download.springer.com/static/pdf/756/art%253A10.1007%252Fs11571-014-9308-y.pdf?auth66=1426794656_e33517b754ecaf12b1d1677bc449bd5&ext=.pdf	Not RCT
Schreiner, I. and Malcolm, J. P. (2008). The Benefits of Mindfulness Meditation: Changes in Emotional States of Depression, Anxiety, and Stress. <i>Behavior Change</i> , 25(3): 156-168.	
Schroder, A., Heider, J., Zaby, A., and Gollner, R. (2013). Cognitive behavioral therapy versus progressive muscle relaxation training for multiple somatoform symptoms: results of a randomized controlled trial. <i>Cognitive Therapy and Research</i> , 37(2), 296-306. doi: 10.1007/s10608-012-9474-3	Does not report data for MDD
Schroevers, M. J., and Brandsma, R. (2010). Is learning mindfulness associated with improved affect after mindfulness-based cognitive therapy? <i>British Journal of Psychology</i> , 101, 95-107. doi: 10.1348/000712609x424195	Does not report data for MDD
Schroevers, M. J., Annika, T. K., Keers, J. C., Links, T. P., Sanderman, R., and Fler, J. (2013). Individual mindfulness-based cognitive therapy for people with diabetes: A pilot randomized controlled trial. <i>Mindfulness</i> . doi: 10.1007/s12671-013-0235-5	Does not report data for MDD
Schuch, F. B., "Progress in the Study of the Effects of Exercise on Affective and Anxiety Disorders," <i>Front Psychiatry</i> , Vol. 5, 2014, p. 153. http://journal.frontiersin.org/article/10.3389/fpsy.2014.00153/pdf	Not RCT
Selfridge, N. (2012). MBSR for type 2 DM: does reducing stress reduce complications? <i>Integrative Medicine Alert</i> , 15(4), 42-44.	Does not report data for MDD
Sendhilkumar, R., Gupta, A., Nagarathna, R., and Taly, A. B. (2013). Effect of pranayama and meditation as an add-on therapy in rehabilitation of patients with Guillain-Barré syndrome—a randomized control pilot study. <i>Disability and Rehabilitation: An International, Multidisciplinary Journal</i> , 35(1), 57-62. doi: 10.3109/09638288.2012.687031	Does not report data for MDD
Sengoku, M., Murata, H., Kawahara, T., Imamura, K. and Nakagome, K. (2010). Does daily Naikan therapy maintain the efficacy of intensive Naikan therapy against depression? <i>Psychiatry and Clinical Neurosciences</i> . 64: 44–51.	Not RCT
Sephton, S. E., Salmon, P., Weissbecker, I., Ulmer, C., Floyd, A., Hoover, K., and Studts, J. L. (2007). Mindfulness meditation alleviates depressive symptoms in women with fibromyalgia: results of a randomized clinical trial. <i>Arthritis & Rheumatology</i> , 57(1), 77-85. doi: 10.1002/art.22478	Does not report data for MDD
SeyedAlinaghi, S., Jam, S., Foroughi, M., Imani, A., Mohraz, M., Djavid, G. E., and Black, D. S. (2012). Randomized controlled trial of mindfulness-based stress reduction delivered to human immunodeficiency virus-positive patients in iran: effects on CD4(+) T Lymphocyte count and medical and psychological symptoms. <i>Psychosomatic Medicine</i> , 74(6), 620-627. doi: 10.1097/PSY.0b013e31825abfaa	Does not report data for MDD
Shand, F. L., Ridani, R., Tighe, J., and Christensen, H. (2013). The effectiveness of a suicide prevention app for indigenous Australian youths: study protocol for a randomized controlled trial. <i>Trials</i> , 14, 396. doi: 10.1186/1745-6215-14-396	Does not report data for meditation for MDD

Publication	Exclusion Reason
Shapiro, D. Cook, I.A., Davydov, D.M., Ottaviani, C., Leuchter, A.F., and Abrams, M. (2007) Yoga as a Complementary Treatment of Depression: Effects of Traits and Moods on Treatment Outcome. <i>eCAM</i> , 4(4)493–502.	Not RCT
Shapiro, S. L., Schwartz, G. E., and Bonner, G. (1998). Effects of mindfulness-based stress reduction on medical and premedical students. <i>Journal of Behavioral Medicine</i> , 21(6), 581-599.	Does not report data for MDD
Sharma, V. K., S. Das, S. Mondal, U. Goswami, and A. Gandhi, "Effect of sahaj yoga on depressive disorders," <i>Indian Journal of Physiology and Pharmacology</i> , Vol. 49, No. 4, 2005, pp. 462-468. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L41565806	Not MBCT
Sharma, M. P., Sudhir, P. M., and Narayan, R. (2013). Effectiveness of mindfulness-based cognitive therapy in persons with depression: a preliminary investigation. <i>Journal of the Indian Academy of Applied Psychology</i> , 39(1), 43-50.	Not RCT
Sharma, V. K., Das, S., Mondal, S., and Goswami, U. (2007). Comparative effect of Sahaj Yoga on EEG in patients of major depression and healthy subjects. <i>Biomedicine</i> , 27(3), 95-99.	Does not report relevant outcome data
Sharplin, G. R., Jones, S. B., Hancock, B., Knott, V. E., Bowden, J. A., and Whitford, H. S. (2010). Mindfulness-based cognitive therapy: an efficacious community-based group intervention for depression and anxiety in a sample of cancer patients. <i>Medical Journal of Australia</i> , 193(5 Suppl), S79-82.	Does not report data for MDD
Shawyer, F., G. N. Meadows, F. Judd, P. R. Martin, Z. Segal, and L. Piterman, "The Dare Study of Relapse Prevention in Depression: Design for a Phase 1/2 Translational Randomised Controlled Trial Involving Mindfulness-Based Cognitive Therapy and Supported Self Monitoring," <i>BMC Psychiatry</i> , Vol. 12, No. 1, 2014. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L600504259	Study protocol
Shennan, C., Payne, S., and Fenlon, D. (2011). What is the evidence for the use of mindfulness-based interventions in cancer care? A review. <i>Psychooncology</i> , 20(7), 681-697. doi: 10.1002/pon.1819	Systematic review
Sheppard, W. D., Staggers, F. J., and John, L. (1997). The effects of a stress management program in a high security government agency. <i>Anxiety Stress and Coping</i> , 10(4), 341-350. doi: 10.1080/10615809708249308	Does not report data for MDD
Shonin, E., W. V. Gordon, and M. D. Griffiths, "Are There Risks Associated with Using Mindfulness in the Treatment of Psychopathology?," <i>Clinical Practice</i> , Vol. 11, No. 4, 2014, pp. 389-392. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L600099441	Background
Silverstein, R. G., Brown, A. C., Roth, H. D., and Britton, W. B. (2011). Effects of mindfulness training on body awareness to sexual stimuli: implications for female sexual dysfunction. <i>Psychosomatic Medicine</i> , 73(9), 817-825. doi: 10.1097/PSY.0b013e318234e628	Does not report data for MDD
Simpson, J., and Mapel, T. (2011). An investigation into the health benefits of mindfulnessbased stress reduction (MBSR) for people living with a range of chronic physical illnesses in new Zealand. <i>New Zealand Medical Journal</i> , 124(1338), 68-75.	Does not report data for MDD
Singh, A. (2012). Use of mindfulness-based therapies in psychiatry. <i>Progress in Neurology and Psychiatry</i> , 16(6), 7-11.	Nonsystematic review
Singh, B. B., Berman, B. M., Hadhazy, V. A., and Creamer, P. (1998). A pilot study of cognitive behavioral therapy in fibromyalgia. <i>Alternative Therapies In Health And Medicine</i> , 4(2), 67-70.	Does not report data for MDD

Publication	Exclusion Reason
Singh, R. H. (1986). Evaluation of some Indian traditional methods of promotion of mental health. <i>Activitas Nervosa Superior</i> , 28(1), 67-69.	Does not report data for MDD
Sipe, W. E., and Eisendrath, S. J. (2012). Mindfulness-based cognitive therapy: theory and practice. <i>Canadian Journal of Psychiatry</i> , 57(2), 63-69.	Nonsystematic review
Sjosten, N., Vaapio, S., and Kivela, S. L. (2008). The effects of fall prevention trials on depressive symptoms and fear of falling among the aged: a systematic review. <i>Aging & Mental Health</i> , 12(1), 30-46. doi: 10.1080/13607860701366079	Does not report data for meditation for MDD
Skowronek, I. B., A. Mounsey, and L. Handler, "Clinical Inquiry: Can Yoga Reduce Symptoms of Anxiety and Depression?," <i>J Fam Pract</i> , Vol. 63, No. 7, Jul, 2014, pp. 398-407.	Review
Sloman, R. (2002). Relaxation and imagery for anxiety and depression control in community patients with advanced cancer. <i>Cancer Nursing</i> , 25(6), 432-435.	Does not report data for MDD
Smeeding, S. J. W., Bradshaw, D. H., Kumpfer, K. L., Trevithick, S., and Stoddard, G. J. (2011). Outcome evaluation of the veterans affairs salt lake city integrative health clinic for chronic nonmalignant pain. <i>Clinical Journal of Pain</i> , 27(2), 146-155.	Does not report data for meditation for MDD
Smelson, D., Chen, K. W., Ziedonis, D., Andes, K., Lennox, A., Callahan, L., Rodrigues, S. and Eisenberg, D. (2013). A pilot study of Qigong for reducing cocaine craving early in recovery. <i>Journal of Alternative and Complementary Medicine</i> , 19(2), 97-101. doi: 10.1089/acm.2012.0052	Does not report data for MDD
Smith, A. (2004). Clinical uses of mindfulness training for older people. <i>Behavioural and Cognitive Psychotherapy</i> , 32(4), 423-430. doi: 10.1017/s1352465804001602	Nonsystematic review
Smith, B. W., Shelley, B. M., Dalen, J., Wiggins, K., Tooley, E., and Bernard, J. (2008). A pilot study comparing the effects of mindfulness-based and cognitive-behavioral stress reduction. <i>Journal of Alternative and Complementary Medicine</i> , 14(3), 251-258. doi: 10.1089/acm.2007.0641	Does not report data for MDD
Smith, B. W., Shelley, B. M., Leahigh, L., and Vanleit, B. (2006). A preliminary study of the effects of a modified mindfulness intervention on binge eating. <i>Complementary Health Practice Review</i> , 11(3), 133-143.	Does not report data for MDD
Smith, J. A., Greer, T., Sheets, T., and Watson, S. (2011). Is there more to yoga than exercise? <i>Alternative Therapies In Health And Medicine</i> , 17(3), 22-29.	Does not report data for MDD
Smith, K. B., and Pukall, C. F. (2009). An evidence-based review of yoga as a complementary intervention for patients with cancer. <i>Psycho-Oncology</i> , 18(5), 465-475.	Systematic review
Smith, W. P., Compton, W. C., and West, W. B. (1995). Meditation as an adjunct to a happiness enhancement program. <i>Journal of Clinical Psychology</i> , 51(2), 269-273.	Does not report data for MDD
Snaith, P. R., Owens, D., and Kennedy, E. (1992). An outcome study of a brief anxiety management programme: Anxiety Control Training. <i>Irish Journal of Psychological Medicine</i> , 9(2), 111-114.	Does not report data for MDD
Snippe, E., Schroevers, M. J., Tovote, K. A., Sanderman, R., Emmelkamp, P. M. and Fleer, J. (2015). "Patients' outcome expectations matter in psychological interventions for patients with diabetes and comorbid depressive symptoms," <i>Cognitive Therapy and Research</i> , 1-11.	Does not report data for MDD
Spahn, G., Choi, K. E., Kennemann, C., Ludtke, R., Franken, U., Langhorst, J., Paul, A. and Dobos, G. J. (2013). Can a multimodal mind-body program enhance the treatment effects of physical activity in breast cancer survivors with chronic tumor-associated fatigue? A randomized controlled trial. <i>Integrative Cancer Therapies</i> , 12(4), 291-300. doi: 10.1177/1534735413492727	Does not report data for MDD

Publication	Exclusion Reason
Spek, A. A., van Ham, N. C., and Nyklicek, I. (2013). Mindfulness-based therapy in adults with an autism spectrum disorder: a randomized controlled trial. <i>Research in Developmental Disabilities</i> , 34(1), 246-253. doi: 10.1016/j.ridd.2012.08.009	Does not report data for MDD
Splevins, K., Smith, A., and Simpson, J. (2009). Do improvements in emotional distress correlate with becoming more mindful? A study of older adults. <i>Aging & Mental Health</i> , 13(3), 328-335. doi: 10.1080/13607860802459807	Does not report data for MDD
Srinivasan, S., L. P. Reagan, J. W. Hardin, M. Matthews, E. Leaphart, C. A. Grillo, M. Neese, A. Johnson, J. Gossard, S. Chapman, and T. Brinkley, "Adjunctive Tai Chi in Geriatric Depression with Comorbid Arthritis: A Randomized, Controlled Trial," <i>American Journal of Geriatric Psychiatry</i> , Vol. 22, No. 3, Mar, 2014, pp. S135-S136. <Go to ISI>://WOS:000336081800150	Not MBCT
Srivastava, M., Talukdar, U., and Lahan, V. (2011). Meditation for the management of adjustment disorder anxiety and depression. <i>Complementary Therapies in Clinical Practice</i> , 17(4), 241-245. doi: 10.1016/j.ctcp.2011.04.007	Does not report data for MDD
Stan, D. L., Collins, N. M., Olsen, M. M., Croghan, I., and Pruthi, S. (2012). The evolution of mindfulness-based physical interventions in breast cancer survivors. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2012, 758641. doi: 10.1155/2012/758641	Systematic review
Stein, D. J., Ives-Deliperi, V., and Thomas, K. G. F. (2008). Psychobiology of mindfulness. <i>CNS Spectrums</i> , 13(9), 752-756.	Nonsystematic review
Stenlund, T., Ahlgren, C., Lindahl, B., Burell, G., Steinholtz, K., Edlund, C., Nilsson, L., Knutsson, A. and Birgander, L. S. (2009). Cognitively oriented behavioral rehabilitation in combination with Qigong for patients on long-term sick leave because of burnout: REST--a randomized clinical trial. <i>International Journal of Behavioral Medicine</i> , 16(3), 294-303. doi: 10.1007/s12529-008-9011-7	Not MBCT
Stenlund, T., Birgander, L. S., Lindahl, B., Nilsson, L., and Ahlgren, C. (2009). Effects of Qigong in patients with burnout: a randomized controlled trial. <i>Journal of Rehabilitation Medicine</i> , 41(9), 761-767. doi: 10.2340/16501977-0417	Does not report data for MDD
Stenlund, T., Nordin, M., and Jarvholm, L. S. (2012). Effects of rehabilitation programmes for patients on long-term sick leave for burnout: a 3-year follow-up of the REST study. <i>Journal of Rehabilitation Medicine</i> , 44(8), 684-690. doi: 10.2340/16501977-1003	Does not report data for MDD
Stevinson, C. (2001). Preliminary results suggest that yoga can alleviate depression. <i>Focus on Alternative and Complementary Therapies</i> , 6(1), 27-28.	Does not report data for MDD
Stotter, A., Mitsche, M., Endler, P. C., Oleksy, P., Kamenschek, D., Mosgoeller, W., and Haring, C. (2013). Mindfulness-based touch therapy and mindfulness practice in persons with moderate depression. <i>Body, Movement and Dance in Psychotherapy</i> , 8(3), 183-198.	Does not report data for meditation for MDD
Strauss, C., K. Cavanagh, A. Oliver, and D. Pettman, "Mindfulness-Based Interventions for People Diagnosed with a Current Episode of an Anxiety or Depressive Disorder: A Meta-Analysis of Randomised Controlled Trials," <i>PLoS One</i> , Vol. 9, No. 4, 2014, p. e96110.	Systematic review
Strauss, C., M. Hayward, and P. Chadwick, "Group person-based cognitive therapy for chronic depression: A pilot randomized controlled trial," <i>British Journal of Clinical Psychology</i> , Vol. 51, No. 3, Sep, 2012, pp. 345-350.	Not MBCT

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Sullivan, M. J., Wood, L., Terry, J., Brantley, J., Charles, A., McGee, V., Johnson, D., Krucoff, M. W., Rosenberg, B., Bosworth, H. B., Adams, K. and Cuffe, M. S. (2009). The Support, Education, and Research in Chronic Heart Failure Study (SEARCH): a mindfulness-based psychoeducational intervention improves depression and clinical symptoms in patients with chronic heart failure. <i>American Heart Journal</i> , 157(1), 84-90. doi: 10.1016/j.ahj.2008.08.033	Does not report data for MDD
Sundquist, J., A. Lilja, K. Palmer, A. A. Memon, X. Wang, L. M. Johansson, and K. Sundquist, "Mindfulness Group Therapy in Primary Care Patients with Depression, Anxiety and Stress and Adjustment Disorders: Randomised Controlled Trial," <i>Br J Psychiatry</i> , Vol. 206, No. 2, Feb, 2015, pp. 128-135. http://bjp.rcpsych.org/content/early/2014/11/11/bjp.bp.114.150243	Does not report data for MDD
Surawy, C., Roberts, J., and Silver, A. (2005). The effect of mindfulness training on mood and measures of fatigue, activity, and quality of life in patients with chronic fatigue syndrome on a hospital waiting list: A series of exploratory studies. <i>Behavioural and Cognitive Psychotherapy</i> , 33(1), 103-109. doi: 10.1017/s135246580400181x	Does not report data for MDD
Suzuki, K., Uchida, S., Kimura, T., and Katamura, H. (2012). A large cross-sectional, descriptive study of self-reports after biofield therapy in Japan: demography, symptomology, and circumstances of treatment administration. <i>Alternative Therapies in Health and Medicine</i> , 18(4), 38-50.	Does not report data for MDD
Tabak, N. T., and E. Granholm, "Mindful Cognitive Enhancement Training for Psychosis: A Pilot Study," <i>Schizophr Res</i> , Vol. 157, No. 1-3, Aug, 2014, pp. 312-313. http://ac.els-cdn.com/S0920996414002916/1-s2.0-S0920996414002916-main.pdf?_tid=7b49f4e6-ce6e-11e4-b362-00000aacb35f&acdnat=1426793643_365ee76a424001c2174b0902560497eb	Does not report data for MDD
Tang, Y. Y. (2012). Neurobiological mechanisms of a mindfulness-based integrative body-mind training intervention on depression. <i>Psychophysiology</i> , 49, S22-S22.	Conference proceeding
Targ, E. F., and Levine, E. G. (2002). The efficacy of a mind-body-spirit group for women with breast cancer: a randomized controlled trial. <i>General Hospital Psychiatry</i> , 24(4), 238-248.	Does not report data for MDD
Taylor-Piliae, R. E., and Haskell, W. L. (2007). Tai Chi exercise and stroke rehabilitation. <i>Topics in Stroke Rehabilitation</i> , 14(4), 9-22.	Nonsystematic review
Teasdale, J. D. (1999). Metacognition, mindfulness and the modification of mood disorders. <i>Clinical Psychology and Psychotherapy</i> , 6(2), 146-155. doi: 10.1002/(sici)1099-0879(199905)6:2<146::aid-cpp195>3.0.co;2-e	Nonsystematic review
Teasdale, J. D., Segal, Z., and Williams, J. M. (1995). How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help? <i>Behaviour Research and Therapy</i> , 33(1), 25-39.	Nonsystematic review
Tekur, P., Nagarathna, R., Chametcha, S., Hankey, A., and Nagendra, H. R. (2012). A comprehensive yoga programs improves pain, anxiety and depression in chronic low back pain patients more than exercise: an RCT. <i>Complementary Therapies in Medicine</i> , 20(3), 107-118. doi: 10.1016/j.ctim.2011.12.009	Does not report data for MDD
Telles, S., Singh, N., and Balkrishna, A. (2012). Managing Mental Health Disorders Resulting from Trauma through Yoga: A Review. <i>Depression Research and Treatment</i> , 2012, 401513. doi: 10.1155/2012/401513	Nonsystematic review
Thachil, A. F., Mohan, R., and Bhugra, D. (2007). The evidence base of complementary and alternative therapies in depression. <i>Journal of Affective Disorders</i> , 97(1-3), 23-35.	Systematic review

Publication	Exclusion Reason
Thompson, N. J., Walker, E. R., Obolensky, N., Winning, A., Barmon, C., Diiorio, C., and Compton, M. T. (2010). Distance delivery of mindfulness-based cognitive therapy for depression: project UPLIFT. <i>Epilepsy & Behavior</i> , 19(3), 247-254. doi: 10.1016/j.yebeh.2010.07.031	Does not report data for MDD
Tloczynski, J., Santucci, A., and Astor-Stetson, E. (2000). Perception of visual illusions by novice and longer-term meditators. <i>Perceptual and Motor Skills</i> , 91(3 Pt 1), 1021-1026.	Does not report data for MDD
Tloczynski, J., and Tantriella, M. (1998). A comparison of the effects of Zen breath meditation or relaxation on college adjustment. <i>Psychologia</i> , 41(1), 32-43.	Does not report data for MDD
Toneatto, T., and Nguyen, L. (2007). Does mindfulness meditation improve anxiety and mood symptoms? A review of the controlled research. <i>Canadian Journal of Psychiatry</i> , 52(4), 260-266.	Systematic review
Tovote, K. A., Flee, J., Snippe, E., Peeters, A. C., Emmelkamp, P. M., Sanderman, R., Links, T. P., and Schroevers, M. J. (2014). "Individual mindfulness-based cognitive therapy and cognitive behavior therapy for treating depressive symptoms in patients with diabetes: results of a randomized controlled trial," <i>Diabetes care</i> , 37(9), 2427-2434.	Does not report data for MDD
Trieger, R. (2011). Open Heart Yoga. <i>Topics in Geriatric Rehabilitation</i> , 27(2), 110-115. doi: 10.1097/TGR.0b013e31821bfffce	Does not report data for MDD
Tsang, H. W., Chan, E. P., and Cheung, W. M. (2008). Effects of mindful and non-mindful exercises on people with depression: a systematic review. <i>Br Journal of Clinical Psychology</i> , 47(Pt 3), 303-322. doi: 10.1348/014466508x279260	Systematic review
Tsang, H. W., Fung, K. M., Chan, A. S., Lee, G., and Chan, F. (2006). Effect of a Qigong exercise programme on elderly with depression. <i>International Journal of Geriatric Psychiatry</i> , 21(9), 890-897. doi: 10.1002/gps.1582	Does not report data for MDD
Tsang, H. W. H. (2009). Neurophysiological effects of Qigong exercise program on depressed elderly with chronic medical illness. <i>Psychophysiology</i> , 46, S156-S157.	Conference proceeding
Tsang, H. W., Lee, J. L., Au, D. W., Wong, K. K., and Lai, K. W. (2013). Developing and testing the effectiveness of a novel health qigong for frail elders in Hong Kong: a preliminary study. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 827392. doi: 10.1155/2013/827392	Does not report data for MDD
Tsang, H. W., Mok, C. K., Au Yeung, Y. T., and Chan, S. Y. (2003). The effect of Qigong on general and psychosocial health of elderly with chronic physical illnesses: a randomized clinical trial. <i>International Journal of Geriatric Psychiatry</i> , 18(5), 441-449. doi: 10.1002/gps.861	Does not report data for MDD
Tsang, H. W., Tsang, W. W., Jones, A. Y., Fung, K. M., Chan, A. H., Chan, E. P., and Au, D. W. (2013). "Psycho-physical and neurophysiological effects of qigong on depressed elders with chronic illness," <i>Aging Ment Health</i> , 17(3), 336-348. http://www.tandfonline.com/doi/pdf/10.1080/13607863.2012.732035	Does not report data for MDD
Tze-Chun, T., Huang, S., and Liu, J. (2012). Short Mindfulness-Based Cognitive Therapy (MBCT) to depression, fatigue, and disability in breast cancer patients: a preliminary randomized control study. <i>Neuro-Oncology</i> , 14, 20-20.	Conference proceeding
Uebelacker, L. A., Epstein-Lubow, G., Gaudiano, B. A., Tremont, G., Battle, C. L., and Miller, I. W. (2010). Hatha yoga for depression: critical review of the evidence for efficacy, plausible mechanisms of action, and directions for future research. <i>Journal of Psychiatric Practice</i> , 16(1), 22-33. doi: 10.1097/01.pra.0000367775.88388.96	Systematic review

Publication	Exclusion Reason
Uebelacker, L. A., Tremont, G., Epstein-Lubow, G., Gaudiano, B. A., Gillette, T., Kalibatseva, Z. and Miller, I. W. (2010). Open trial of Vinyasa yoga for persistently depressed individuals: evidence of feasibility and acceptability. <i>Behavior Modification</i> , 34(3) 247–264.	Not RCT
Umadevi, P., Ramachandra, Varambally, S., Philip, M., and Gangadhar, B. N. (2013). Effect of yoga therapy on anxiety and depressive symptoms and quality-of-life among caregivers of in-patients with neurological disorders at a tertiary care center in India: A randomized controlled trial. <i>Indian Journal of Psychiatry</i> , 55(Suppl 3), S385-389. doi: 10.4103/0019-5545.116304	Does not report data for MDD
Van Dam, N. T., A. L. Hobkirk, S. C. Sheppard, R. Aviles-Andrews, and M. Earleywine, "How Does Mindfulness Reduce Anxiety, Depression, and Stress? An Exploratory Examination of Change Processes in Wait-List Controlled Mindfulness Meditation Training," <i>Mindfulness</i> , Vol. 5, No. 5, Oct, 2014, pp. 574-588. <Go to ISI>://WOS:000346635000011 http://download.springer.com/static/pdf/276/art%253A10.1007%252Fs12671-013-0229-3.pdf?auth66=1426794480_407dc7ea43bacfb82bc031ef1a070e5c&ext=.pdf	Does not report data for MDD
van der Heijden, M. M. P., van Dooren, F. E. P., Pop, V. J. M., and Pouwer, F. (2013). Effects of exercise training on quality of life, symptoms of depression, symptoms of anxiety and emotional well-being in type 2 diabetes mellitus: a systematic review. <i>Diabetologia</i> , 56(6), 1210-1225. doi: 10.1007/s00125-013-2871-7	Does not report data for meditation for MDD
van der Watt, G., Laugharne, J., and Janca, A. (2008). Complementary and alternative medicine in the treatment of anxiety and depression. <i>Current Opinion in Psychiatry</i> , 21(1), 37-42. doi: 10.1097/YCO.0b013e3282f2d814	Nonsystematic review
Van Puymbroeck, M., and Hsieh, P. (2010). The influence of mindfulness-based stress reduction and walking on the psychological well-being of female informal caregivers: a pilot study. <i>American Journal of Recreation Therapy</i> , 9(1), 15-25. doi: 10.5055/ajrt.2010.0002	Does not report data for MDD
van Son, J., Nyklicek, I., Pop, V. J., Blonk, M. C., Erdtsieck, R. J., Spooren, P. F., Toorians, A. W., and Pouwer, F. (2013). The effects of a mindfulness-based intervention on emotional distress, quality of life, and HbA(1c) in outpatients with diabetes (DiaMind): a randomized controlled trial. <i>Diabetes Care</i> , 36(4), 823-830. doi: 10.2337/dc12-1477	Does not report data for MDD
van Vugt, M. K., Hitchcock, P., Shahar, B., and Britton, W. (2012). The effects of mindfulness-based cognitive therapy on affective memory recall dynamics in depression: a mechanistic model of rumination. <i>Frontiers in Human Neuroscience</i> , 6, 257. doi: 10.3389/fnhum.2012.00257	Does not report data for MDD
Vancampfort, D., Vanderlinden, J., De Hert, M., Adamkova, M., Skjaerven, L. H., Catalan-Matamoros, D., Lundvik-Gyllensten, A., Gómez-Conesa, A., Rutger I. and Probst, M. (2013). A systematic review on physical therapy interventions for patients with binge eating disorder. <i>Disability and Rehabilitation</i> , 35(26), 2191-2196. doi: 10.3109/09638288.2013.771707	Systematic review
Varambally, S., Vidyendaran, S., Sajjanar, M., Thirthalli, J., Hamza, A., Nagendra, H. R., & Gangadhar, B. N. (2013). Yoga-based intervention for caregivers of outpatients with psychosis: a randomized controlled pilot study. <i>Asian Journal of Psychiatry</i> , 6(2), 141-145. doi: 10.1016/j.ajp.2012.09.017	Does not report data for MDD

Publication	Exclusion Reason
Varghese, S. P., M. M. Koola, R. I. Eiger, and M. Devens, "Opioid Use Remits, Depression Remains," <i>Current Psychiatry</i> , Vol. 13, No. 8, 2014, pp. 45-50. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L373704923	Case study
Vedamurthachar, A., Janakiramaiah, N., Hegde, J. M., Shetty, T. K., Subbakrishna, D. K., Sureshbabu, S. V., and Gangadhar, B. N. (2006). Antidepressant efficacy and hormonal effects of Sudarshana Kriya Yoga (SKY) in alcohol dependent individuals. <i>Journal of Affective Disorders</i> , 94(1-3), 249-253. doi: 10.1016/j.jad.2006.04.025	Does not report data for MDD
Veehof, M. M., Oskam, M. J., Schreurs, K. M., and Bohlmeijer, E. T. (2011). Acceptance-based interventions for the treatment of chronic pain: a systematic review and meta-analysis. <i>Pain</i> , 152(3), 533-542. doi: 10.1016/j.pain.2010.11.002	Systematic review
Vega, B. R., C. B. Perez, A. Palaotarrero, and A. F. Liria, "Mindfulness-Based Narrative Therapy for Depression in Cancer Patients," <i>Clinical Psychology & Psychotherapy</i> , Vol. 21, No. 5, Sep-Oct, 2014, pp. 411-419. <Go to ISI>://WOS:000342897900004 http://onlinelibrary.wiley.com/store/10.1002/cpp.1847/asset/cpp1847.pdf?v=1&t=i7gjzq43&s=8169011ab0faa0f90811fd0d35128ed57fdea902	Nonsystematic review
Verhoeven, J. E., J. N. Vrijzen, I. Van Oostrom, A. E. M. Speckens, and M. Rinck, "Attention Effects of Mindfulness-Based Cognitive Therapy in Formerly Depressed Patients," <i>Journal of Experimental Psychopathology</i> , Vol. 5, No. 4, 2014, pp. 414-424. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2015-01210-002&site=ehost-live	Not RCT
Vieten, C., and Astin, J. (2008). Effects of a mindfulness-based intervention during pregnancy on prenatal stress and mood: results of a pilot study. <i>Archives of Women's Mental Health</i> , 11(1), 67-74. doi: 10.1007/s00737-008-0214-3	Does not report data for MDD
Vollestad, J., Nielsen, M. B., and Nielsen, G. H. (2012). Mindfulness- and acceptance-based interventions for anxiety disorders: a systematic review and meta-analysis. <i>British Journal of Clinical Psychology</i> , 51(3), 239-260. doi: 10.1111/j.2044-8260.2011.02024.x	Systematic review
Vollestad, J., Sivertsen, B., and Nielsen, G. H. (2011). Mindfulness-based stress reduction for patients with anxiety disorders: evaluation in a randomized controlled trial. <i>Behaviour Research and Therapy</i> , 49(4), 281-288. doi: 10.1016/j.brat.2011.01.007	Does not report data for MDD
Waelde, L. C., Thompson, L., and Gallagher-Thompson, D. (2004). A pilot study of a yoga and meditation intervention for dementia caregiver stress. <i>Journal of Clinical Psychology</i> , 60(6), 677-687. doi: 10.1002/jclp.10259	Does not report data for MDD
Walker, I. D., and Gonzalez, E. W. (2007). Review of intervention studies on depression in persons with multiple sclerosis. <i>Issues in Mental Health Nursing</i> , 28(5), 511-531. doi: 10.1080/01612840701344480	Systematic review
Waller, B., Carlson, J., and Englar-Carlson, M. (2006). Treatment and relapse prevention of depression using mindfulness-based cognitive therapy and Adlerian concepts. <i>Journal of Individual Psychology</i> , 62(4), 443-454.	Nonsystematic review
Wang, C. (2008). Tai Chi improves pain and functional status in adults with rheumatoid arthritis: results of a pilot single-blinded randomized controlled trial. <i>Medicine and Sport Science</i> , 52, 218-229. doi: 10.1159/000134302	Does not report data for MDD
Wang, C. (2012). Role of Tai Chi in the treatment of rheumatologic diseases. <i>Current Rheumatology Reports</i> , 14(6), 598-603. doi: 10.1007/s11926-012-0294-y	Nonsystematic review

Publication	Exclusion Reason
Wang, C., Bannuru, R., Ramel, J., Kupelnick, B., Scott, T., and Schmid, C. H. (2010). Tai Chi on psychological well-being: systematic review and meta-analysis. <i>BMC Complementary and Alternative Medicine</i> , 10, 23. doi: 10.1186/1472-6882-10-23	Systematic review
Wang, C., Schmid, C. H., Hibberd, P. L., Kalish, R., Roubenoff, R., Roness, R., and McAlindon, T. (2009). Tai Chi is effective in treating knee osteoarthritis: a randomized controlled trial. <i>Arthritis & Rheumatology</i> , 61(11), 1545-1553. doi: 10.1002/art.24832	Does not report data for MDD
Wang, C. W., Chan, C. L., Ho, R. T., Tsang, H. W., Chan, C. H., and Ng, S. M. (2013). The effect of qigong on depressive and anxiety symptoms: a systematic review and meta-analysis of randomized controlled trials. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 716094. doi: 10.1155/2013/716094	Systematic review
Wang, C. W., Chan, C. L. W., Ho, R. T. H., Tsang, H. W. H., Chan, C. H. Y., and Ng, S. M. (2013). The Effect of Qigong on depressive and anxiety symptoms: a systematic review and meta-analysis of randomized controlled trials. <i>Evidence-Based Complementary and Alternative Medicine</i> . doi: 10.1155/2013/716094	Systematic review
Wang, F., Lee, E. K., Wu, T., Benson, H., Fricchione, G., Wang, W., and Yeung, A. S. (2013). The effects of Tai Chi on depression, anxiety, and psychological well-being: a systematic review and meta-analysis. <i>International Journal of Behavioral Medicine</i> . doi: 10.1007/s12529-013-9351-9	Systematic review
Wang, F., Man, J. K., Lee, E. K., Wu, T., Benson, H., Fricchione, G. L., . . . Yeung, A. (2013). The effects of Qigong on anxiety, depression, and psychological well-being: a systematic review and meta-analysis. <i>Evidence-Based Complementary and Alternative Medicine</i> , 2013, 152738. doi: 10.1155/2013/152738	Systematic review
Wang, F., Wang, W., Zhang, R., Lin, Y., Hong, L., Zhao, Y., . . . Suzukiakio. (2008). Clinical observation on physiological and psychological effects of Eight-Section Brocade on type 2 diabetic patients. <i>Journal of Traditional Chinese Medicine</i> , 28(2), 101-105.	Does not report data for MDD
Wang, W. C., Zhang, A. L., Rasmussen, B., Lin, L. W., Dunning, T., Kang, S. W., Park, B. J. and Lo, S. K. (2009). The effect of Tai Chi on psychosocial well-being: a systematic review of randomized controlled trials. <i>Journal of Acupuncture and Meridian Studies</i> , 2(3), 171-181. doi: 10.1016/s2005-2901(09)60052-2	Systematic review
Wang, W., He, G., Wang, M., Liu, L., and Tang, H. (2012). Effects of patient education and progressive muscle relaxation alone or combined on adherence to continuous positive airway pressure treatment in obstructive sleep apnea patients. <i>Sleep Breath</i> , 16(4), 1049-1057. doi: 10.1007/s11325-011-0600-3	Does not report data for MDD
Wang, W., Sawada, M., Noriyama, Y., Arita, K., Ota, T., and Kishimoto, T. (2009). Effects of Qigong in Tai Chi in the elderly using General Health Questionnaire (GHQ). <i>Journal of Nara Medical Association</i> , 60(5-6), 159-165.	Does not report data for MDD
Wang, W., Sawada, M., Noriyama, Y., Arita, K., Ota, T., Sadamatsu, M., Kiyotou, R., Hirai, M. and Kishimoto, T. (2010). Tai Chi exercise versus rehabilitation for the elderly with cerebral vascular disorder: a single-blinded randomized controlled trial. <i>Psychogeriatrics</i> , 10(3), 160-166. doi: 10.1111/j.1479-8301.2010.00334.x	Does not report data for MDD
Warnecke, E., Quinn, S., Ogden, K., Towle, N., and Nelson, M. R. (2011). A randomised controlled trial of the effects of mindfulness practice on medical student stress levels. <i>Medical Education</i> , 45(4), 381-388. doi: 10.1111/j.1365-2923.2010.03877.x	Does not report data for MDD
Weiss, M., Nordlie, J. W., and Siegel, E. P. (2005). Mindfulness-based stress reduction as an adjunct to outpatient psychotherapy. <i>Psychotherapy and psychosomatics</i> , 74(2), 108-112. doi: 10.1159/000083169	Does not report data for MDD

Publication	Exclusion Reason
Weissbecker, I., Salmon, P., Studts, J. L., Floyd, A. R., Dedert, E. A., and Sephton, S. E. (2002). Mindfulness-based stress reduction and sense of coherence among women with fibromyalgia. <i>Journal of Clinical Psychology in Medical Settings</i> , 9(4), 297-307. doi: 10.1023/a:1020786917988	Does not report data for MDD
Wenneberg, S., Gunnarsson, L. G., and Ahlstrom, G. (2004a). Using a novel exercise programme for patients with muscular dystrophy. Part II: a quantitative study. <i>Disability and Rehabilitation</i> , 26(10), 595-602. doi: 10.1080/09638280410001696665	Does not report data for MDD
Wheeler, A., L. Denson, C. Neil, G. Tucker, M. Kenny, J. F. Beltrame, G. Schrader, and M. Proeve, "Investigating the Effect of Mindfulness Training on Heart Rate Variability in Mental Health Outpatients: A Pilot Study," <i>Behaviour Change</i> , Vol. 31, No. 3, Sep, 2014, pp. 175-188. <Go to ISI>://WOS:000340721000002 http://journals.cambridge.org/download.php?file=%2F5021_959267909E6485416F487CDE1B68A54D_journals_BEC_BEC31_03_S081348391400014Xa.pdf&cover=Y&code=9fcec0952cb31d6281bc6fe8a66d382c	Not RCT
Whitebird, R. R., Kreitzer, M., Crain, A. L., Lewis, B. A., Hanson, L. R., and Enstad, C. J. (2013). Mindfulness-based stress reduction for family caregivers: a randomized controlled trial. <i>Gerontologist</i> , 53(4), 676-686. doi: 10.1093/geront/gns126	Does not report data for MDD
Williams, J. M., Duggan, D. S., Crane, C., and Fennell, M. J. (2006). Mindfulness-based cognitive therapy for prevention of recurrence of suicidal behavior. <i>Journal of Clinical Psychology</i> , 62(2), 201-210. doi: 10.1002/jclp.20223	Case report
Williams, J. M. G. (2004). Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. <i>European Psychiatry</i> , 19, 76S-76S.	Does not report data for MDD
Williams, J. M. G., and Kuyken, W. (2012). Mindfulness-based cognitive therapy: A promising new approach to preventing depressive relapse. <i>British Journal of Psychiatry</i> , 200(5), 359-360.	Background
Williams, J. W., Gierisch, J. M., McDuffie, J., Strauss, J. L., and Nagi, A. (2011). "An overview of complementary and alternative medicine therapies for anxiety and depressive disorders". <i>Supplement to Efficacy of Complementary and Alternative Medicine Therapies for Posttraumatic Stress Disorder</i> . Washington DC: Department of Veterans Affairs.	Systematic review
Williams, K., Abildso, C., Steinberg, L., Doyle, E., Epstein, B., Smith, D., Hobbs, G., Gross, R., Kelley, G. and Cooper, L. (2009). Evaluation of the effectiveness and efficacy of Iyengar yoga therapy on chronic low back pain. <i>Spine</i> , 34(19), 2066-2076. doi: 10.1097/BRS.0b013e3181b315cc	Does not report data for MDD
Wintering, Nancy A., Wilson, Joseph C., and Newberg, Andrew B. (2012). A pilot study to evaluate the physiological effects of a spa retreat that uses caloric restriction and colonic hydrotherapy. <i>Integrative Medicine: A Clinician's Journal</i> , 11(6), 26-32.	Does not report data for MDD
Witkiewitz, K., and Bowen, S. (2010). Depression, craving, and substance use following a randomized trial of mindfulness-based relapse prevention. <i>Journal of Consulting and Clinical Psychology</i> , 78(3), 362-374. doi: 10.1037/a0019172	Does not report data for MDD
Woldt, K. S., "Outcome of Individual Psychological Interventions Following a Cognitive Behavioural Therapy and Mindfulness Model Applied to Adults with Type 1 and Type 2 Diabetes," <i>Diabetic Medicine</i> , Vol. 31, 2014, pp. 152-153. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L71554700	Does not report data for MDD
Wolf, D. B., and Abell, N. (2003). Examining the effects of meditation techniques on psychosocial functioning. <i>Research on Social Work Practice</i> , 13(1), 27-42. doi: 10.1177/104973102237471	Does not report data for MDD

Publication	Exclusion Reason
Wolf, S. L., Barnhart, H. X., Kutner, N. G., McNeely, E., Coogler, C., and Xu, T. (2003). Selected as the best paper in the 1990s: Reducing frailty and falls in older persons: an investigation of Tai Chi and computerized balance training. <i>Journal of the American Geriatrics Society</i> , 51(12), 1794-1803.	Does not report data for MDD
Wolf, S. L., Sattin, R. W., Kutner, M., O'Grady, M., Greenspan, A. I., and Gregor, R. J. (2003). Intense Tai Chi exercise training and fall occurrences in older, transitionally frail adults: a randomized, controlled trial. <i>Journal of the American Geriatrics Society</i> , 51(12), 1693-1701.	Does not report data for MDD
Woltz, P. C., Chapa, D. W., Friedmann, E., Son, H., Akintade, B., and Thomas, S. A. (2012). Effects of interventions on depression in heart failure: a systematic review. <i>Heart Lung</i> , 41(5), 469-483. doi: 10.1016/j.hrtlng.2012.06.002	Systematic review
Wong, S. Y., Mak, W. W., Cheung, E. Y., Ling, C. Y., Lui, W. W., Tang, W. K., Wong, R. LP., Lo, H. HM., Mercer, S. and Ma, H. S. (2011). A randomized, controlled clinical trial: the effect of mindfulness-based cognitive therapy on generalized anxiety disorder among Chinese community patients: protocol for a randomized trial. <i>BMC Psychiatry</i> , 11, 187. doi: 10.1186/1471-244x-11-187	Does not report data for MDD
Woodyard, C. (2011). Exploring the therapeutic effects of yoga and its ability to increase quality of life. <i>International Journal of Yoga (IJoY)</i> , 4(2), 49-54. doi: 10.4103/0973-6131.85485	Systematic review
Woolery, A., Myers, H., Sternlieb, B., and Zeltzer, L. (2004). A yoga intervention for young adults with elevated symptoms of depression. <i>Alternative Therapies In Health And Medicine</i> , 10(2), 60-63.	Does not report data for MDD
Wurtzen, H., Dalton, S. O., Elsass, P., Sumbundu, A. D., Steding-Jensen, M., Karlsen, R. V., Andersen, K. K., Flyger, H. L., Pedersen, A. E. and. Johansen, C. (2013). Mindfulness significantly reduces self-reported levels of anxiety and depression: results of a randomised controlled trial among 336 Danish women treated for stage I-III breast cancer. <i>European Journal of Cancer</i> , 49(6), 1365-1373. doi: 10.1016/j.ejca.2012.10.030	Does not report data for MDD
Yeh, G. Y., McCarthy, E. P., Wayne, P. M., Stevenson, L. W., Wood, M. J., Forman, D., Davis, R. B. and Phillips, R. S. (2011). Tai Chi exercise in patients with chronic heart failure: a randomized clinical trial. <i>Archives of Internal Medicine</i> , 171(8), 750-757. doi: 10.1001/archinternmed.2011.150	Not MBCT
Yeh, G. Y., Roberts, D. H., Wayne, P. M., Davis, R. B., Quilty, M. T., and Phillips, R. S. (2010). Tai Chi exercise for patients with chronic obstructive pulmonary disease: a pilot study. <i>Respiratory Care</i> , 55(11), 1475-1482.	Does not report data for MDD
Yeung, A., V. Lepoutre, P. Wayne, G. Yeh, L. E. Slipp, M. Fava, J. W. Denninger, H. Benson, and G. L. Fricchione, "Tai chi treatment for depression in chinese americans: A pilot study," <i>Am American Journal of Physical Medicine & Rehabilitation</i> , Vol. 91, No. 10, Oct, 2012, pp. 863-870.	Not MBCT
Yeung, A. Slipp, L.E., Jacquart, J. Fava, M., Denninger, J.W. Benson, H., Fricchione, G.L. (2013). The Treatment of Depressed Chinese Americans Using Qigong in a Health Care Setting: A Pilot Study. <i>Evidence-Based Complementary and Alternative Medicine</i>	Not RCT
Yoga better for chronic back pain and associated depression. (2009-2010). <i>BackCare Journal</i> , Winter: 4, 4.	Background
Yong, W. K., Lee, S. H., Tae, K. C., Shin, Y. S., Kim, B., Chan, M. K., Cho, S. J., Kim, M. K., Yook, K., Ryu, M., Song, S. K. and Yook, K. H. (2009). Effectiveness of mindfulness-based cognitive therapy as an adjuvant to pharmacotherapy in patients with panic disorder or generalized anxiety disorder. <i>Depression and Anxiety</i> , 26(7), 601-606.	Does not report data for MDD

Publication	Exclusion Reason
Young, L. A. (2011). Mindfulness Meditation: A Primer for Rheumatologists. <i>Rheumatic Disease Clinics of North America</i> , 37(1), 63-75.	Does not report data for MDD
Zainal, N. Z., Booth, S., and Huppert, F. A. (2013). The efficacy of mindfulness-based stress reduction on mental health of breast cancer patients: a meta-analysis. <i>Psychooncology</i> , 22(7), 1457-1465. doi: 10.1002/pon.3171	Systematic review
Zautra, A. J., Davis, M. C., Reich, J. W., Nicassario, P., Tennen, H., Finan, P., Kratz, A., Parrish, B. and Irwin, M. R. (2008). Comparison of cognitive behavioral and mindfulness meditation interventions on adaptation to rheumatoid arthritis for patients with and without history of recurrent depression. <i>Journal of Consulting and Clinical Psychology</i> , 76(3), 408-421. doi: 10.1037/0022-006x.76.3.408	Not MBCT
Zautra, A. J., Davis, M. C., Reich, J. W., Sturgeon, J. A., Arewasikporn A., and Tennen, H. (2012). "Phone-based interventions with automated mindfulness and mastery messages improve the daily functioning for depressed middle-aged community residents," <i>Journal of Psychotherapy Integration</i> , 22(3), 206-228. http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L368451745 http://dx.doi.org/10.1037/a0029573	Does not report data for MDD
Zhang, J., Yang, K. H., Tian, J. H., and Wang, C. M. (2012). Effects of yoga on psychologic function and quality of life in women with breast cancer: a meta-analysis of randomized controlled trials. <i>Journal of Alternative and Complementary Medicine</i> , 18(11), 994-1002. doi: 10.1089/acm.2011.0514	Systematic review
Zhang, L., Layne, C., Lowder, T., and Liu, J. (2012). A Review Focused on the Psychological Effectiveness of Tai Chi on Different Populations. <i>Evidence-Based Complementary and Alternative Medicine</i> , 1-9. doi: 10.1155/2012/678107	Nonsystematic review
Zhao, L., Wu, H., Zhou, X., Wang, Q., Zhu, W., and Chen, J. (2012). Effects of progressive muscular relaxation training on anxiety, depression and quality of life of endometriosis patients under gonadotrophin-releasing hormone agonist therapy. <i>European Journal of Obstetrics & Gynecology and Reproductive Biology</i> , 162(2), 211-215. doi: 10.1016/j.ejogrb.2012.02.029	Does not report data for MDD
Zope, S. A., and Zope, R. A. (2013). Sudarshan kriya yoga: Breathing for health. <i>International Journal of Yoga (IJoY)</i> , 6(1), 4-10. doi: 10.4103/0973-6131.105935	Does not report data for meditation for MDD
Zucker, T. L., Samuelson, K. W., Muench, F., Greenberg, M. A., and Gevirtz, R. N. (2009). The effects of respiratory sinus arrhythmia biofeedback on heart rate variability and posttraumatic stress disorder symptoms: a pilot study. <i>Applied Psychophysiology and Biofeedback</i> , 34(2), 135-143. doi: 10.1007/s10484-009-9085-2	Does not report data for MDD
Zylowska, L., Ackerman, D. L., Yang, M. H., Futrell, J. L., Horton, N. L., Hale, T. S., Pataki, C. and Smalley, S. L. (2008). Mindfulness meditation training in adults and adolescents with ADHD: a feasibility study. <i>Journal of Attention Disorders</i> , 11(6), 737-746. doi: 10.1177/1087054707308502	Does not report data for MDD

Appendix C: Evidence Table

Table C.1: Evidence Table

Study Details	Patients	Intervention/Treatment	Outcomes/Results ¹
<p>Reference: 2839 Barnhofer et al., 2009</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To investigate the effects of MBCT in patients suffering from chronic forms of depression using a randomized controlled design with blind assessments</p> <p>Country: United Kingdom</p> <p>Quality rating: Good</p>	<p>Number of participants: 31 initial, 28 final</p> <p>Method of identifying patients with MDD: Current diagnosis of MDD or presence of residual symptoms following a full episode, defined as either meeting DSM-IV criteria for only four instead of at least five symptoms of depression over the last two weeks or suffering from five or more symptoms for at least half of the days, if symptoms had not been present for most of the days over the past two weeks. Assessed via the Structured Clinical Interview for DSM-IV.</p> <p>Baseline depressive symptom score: BDI (full sample): MBCT+TAU: 29.36 (9.66); TAU: 31.32 (10.79)</p> <p>Average age in years (SD): MBCT+TAU: 42.07 (11.34); TAU: 41.79 (9.52)</p> <p>Gender: MBCT+TAU: 28.6% male; TAU: 35.7% male</p> <p>Inclusion criteria: History of at least three previous episodes of MDD or Chronic Depression; current diagnosis of MDD or presence of residual symptoms following a full episode, defined as either meeting DSM-IV criteria for only four instead of at least five symptoms of depression over the last two weeks or suffering from five or more symptoms for at least half of the days, if</p>	<p>MBCT: Followed standardized manual (Segal et al., 2002) with adjustments to address suicidality and acute symptoms.</p> <p>Dosage: 8 weekly 2-hour sessions, 1 hour homework 6 days each week</p> <p>Co-interventions: TAU: Encouraged to continue any current medication and to attend appointments with their mental health practitioners or other services over the treatment phase as they would have done otherwise.</p> <p>Comparator(s): TAU alone</p> <p>Follow-up: At end of intervention</p>	<p>Depressive symptoms, BDI (full sample): Difference in change in depressive symptom score (BDI) in MBCT+TAU vs. TAU: SMD= -0.92, -1.66 to -0.17</p> <p>Response: Response rate was not significantly different between MBCT+TAU and TAU: RR=0.18, 95% CI 0.02, 1.31</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Study authors reported that there were no adverse events that were deemed to be related to treatment.</p> <p>Antidepressant use: Changes in antidepressant use MBCT+TAU: 2 (14%) TAU: 7 (50%) P=0.052</p>

	<p>symptoms had not been present for most of the days over the past two weeks; history of suicidal ideation (including thoughts of methods of suicide) or suicidal behavior; absence of current mania or hypomania, psychosis, obsessive-compulsive disorder, eating disorder, pervasive developmental disorder or habitual self-harming, substance abuse or dependence that would significantly interfere with the ability to engage in meditation; adequate written and spoken English to complete all study measures; not currently in individual or group psychotherapy and no current ongoing meditation practice; and age between 18 and 65.</p> <p>Exclusion criteria: None reported</p>		
<p>Reference:: 1983 Batink et al., 2013; Geschwind et al., 2012; Forkmann et al., 2014</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To investigate the effect of MBCT on residual depressive symptoms and whether the effect of is contingent on the number of previous depressive episodes</p> <p>Country: Netherlands</p> <p>Quality rating: Fair</p>	<p>Number of participants: 130 initial, 125 final</p> <p>Method of identifying patients with MDD: Residual depression symptomatology (HRSD₁₇ ≥7) after a least one episode of MDD as assessed by the Structured Clinical Interview for DSM-IV</p> <p>Baseline depressive symptom score: <u>HRSD-17</u> 1-2 Episodes: MBCT: 9.6 (3.2); TAU: 10.5 (3.7) 3+ Episodes: MBCT: 11.1 (4.1); TAU: 9.9 (3.4) Full sample: MBCT: 10.3 (3.7); TAU: 10.2 (3.6)</p> <p><u>IDS-SR</u> 1-2 Episodes: MBCT 19.3 (9.4); TAU: 23.8 (8.8) 3+ Episodes: MBCT: 26.0 (11.1); TAU: 20.5 (8.2) Full sample: MBCT 22.4 (10.7); TAU: 22.5 (8.7)</p> <p>Average age in years (SD): 2 or fewer episodes: 42.8 (1.7); 3+ prior episodes: 45.2 (1.2); Overall: 43.9 (9.6); MBCT: 44.6 (9.7); TAU: 43.2 (9.5)</p> <p>Gender: 2 or fewer prior episodes: 30% male; 3+ prior episodes: 19% male Overall: 25% male; MBCT: 21.9% male; TAU:</p>	<p>MBCT: Followed standard protocol (Segal, Williams, and Teasdale, 2002). Sessions included guided meditation, experiential exercises, and discussions, Participants received CDs with guided exercises.</p> <p>Dosage: 8 sessions, 2.5 hours 1x/week plus daily homework exercises (30 to 60 minutes)</p> <p>Co-interventions: Psychological or pharmacological treatment</p> <p>Comparator: TAU: Received psychological and pharmacological treatment</p> <p>Follow-up: At end of intervention</p>	<p>Depressive symptoms, HRSD-17: <u>Full sample:</u> difference in change in depressive symptom score in MBCT+TAU vs. TAU: -0.60, -0.95 to -0.24</p> <p><u>1-2 previous MD episodes:</u> difference in change in depressive symptom score in MBCT+TAU vs. TAU: -0.93, -1.42 to -0.44.</p> <p><u>3+ previous MD episodes:</u> difference in change in depressive symptom score in MBCT+TAU vs. TAU: -0.19, -0.71 to 0.32</p> <p>Depressive symptoms, IDS-SR: <u>Full sample:</u> difference in change in depressive symptom score in MBCT+TAU vs. TAU: SMD= -0.53, -0.88 to -0.18</p> <p><u>1-2 previous MD episodes</u> difference in change in depressive symptom score in MBCT+TAU</p>

	<p>27.3% male</p> <p>Inclusion criteria: Residual depression symptomatology (HRSD₁₇ ≥7) after a least one episode of MDD.</p> <p>Exclusion criteria: Fulfilling criteria for a current major depressive episode, a lifetime diagnosis of schizophrenia, psychotic episodes in the past year, general conditions that made participation in a group intervention impossible, and recent (past four weeks) or upcoming changes in ongoing psychological or pharmacological treatment.</p>		<p>vs. TAU: SMD= -0.93, -1.42 to -0.44</p> <p><u>3+ previous MD episodes</u> difference in change in depressive symptom score in MBCT+TAU vs. TAU: SMD=0.07, -0.44 to 0.58</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Study reported that there were no adverse events.</p> <p>Antidepressant use: NA</p>
<p>Reference: 2621 Bondolfi et al., 2010; Jermann et al., 2013</p> <p>Study design: Multisite (2) RCT</p> <p>Intention-to-treat analysis: Bondolfi et al. (2010): Yes Jermann et al. (2013): N/A no dropout</p> <p>Purpose: Bondolfi et al. (2010): To test if MBCT would reduce the risk of depressive relapse when compared to TAU in the context of the Swiss health care system in a sample of remitted depressed patients with three or more past depressive episodes Jermann et al. (2013): To</p>	<p>Number of participants: Bondolfi et al. (2010): 60 initial, 55 final Jermann et al. (2013): 36 initial and 36 final</p> <p>Method of identifying patients with MDD: ≤Clinical diagnosis of MDD in remission at time of inclusion</p> <p>Baseline depressive symptom score: Bondolfi et al. (2010): NA Jermann et al. (2013): <u>BDI</u> MBCT+TAU: 9.8 (9.8) TAU: 6.9 (6.9)</p> <p><u>MADRS</u> MBCT+TAU: 5.4 (4.8) TAU: 3.8 (4.0)</p> <p>Average age in years: To</p>	<p>MBCT: Followed standardized protocol (Segal et al., 2002)</p> <p>Dosage: 8 weekly 2-hour sessions</p> <p>Co-interventions: TAU, but no antidepressants</p> <p>Comparator(s): TAU: Unrestricted access to any treatment or help service</p> <p>Follow-up: At end of intervention and 3-, 6-, 9-, and 12-months post-intervention</p>	<p>Depressive symptoms, BDI: <u>3 Month Follow-Up</u> Difference in change in depressive symptom score (BDI) in MBCT+TAU vs. TAU between baseline and 3-month post-intervention follow-up: SMD= 0.49, -0.17 to 1.15</p> <p><u>9 Month Follow-Up</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU between baseline and 9-month post-intervention follow-up: SMD=0.82, 0.14 to 1.51</p> <p>Depressive symptoms, MADRS: <u>3 Month Follow-Up</u> Difference in change in depressive symptom score (BDI) in</p>

<p>determine whether cognitive functioning was altered among patients remitted from depression and investigate the possible impact of MBCT on these functions from a longitudinal perspective</p> <p>Country: Switzerland</p> <p>Quality rating: Good</p>	<p>Bondolfi et al. (2010): MBCT+TAU: Median=46 (min-max 27-63); TAU: Median=49 (min-max 24-66)</p> <p>Jermann et al. (2013): MBCT: 45.4 (SD=11.6); TAU: 48.2 (SD=9.4)</p> <p>Gender: Bondolfi et al. (2010): MBCT+TAU: 26% male; TAU: 31% male Jermann et al. (2013): 31% male</p> <p>Inclusion criteria: History of recurrent major depression according to DSM-IV assessed with the Structured Clinical Interview for DSM-IV; at least three past depressive episodes (2 episodes in the past 5 years and at least one in the past 2 years); remission for at least 3 months at time of enrolment; MADRS ≤ 13, corresponding to the baseline score of 10 on the HRSD₁₇; history of treatment with antidepressants but currently off medication for at least 3 months before enrollment.</p> <p>Exclusion criteria: History of schizophrenia or schizoaffective disorder, current substance abuse, eating disorder, obsessive compulsive disorder, organic mental disorder, pervasive developmental disorder, borderline personality disorder, dysthymia with onset before age 20, more than four sessions of CBT ever, current psychotherapy or counseling more frequently than once per month, current practice of meditation more than once per week or yoga more than twice per week.</p>		<p>MBCT+TAU vs. TAU between baseline and 3-month post-intervention follow-up: SMD= 0.31, -0.35 to 0.97</p> <p><u>9 Month Follow-Up</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU between baseline and 9-month post-intervention follow-up: SMD=0.72, 0.05 to 1.39</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse (determined through clinical interview): In ITT sample (over 14 months): Relapse in MBCT+TAU vs TAU RR 0.84, 0.40 to 1.77</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Not reported</p> <p>Antidepressant use: Antidepressant reinstatement: MBCT+TAU: 36% TAU: 31% p=.78</p>
<p>Reference: 2617 Britton et al., 2010</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: No</p>	<p>Number of participants: 26 initial, 20 final</p> <p>Method of identifying patients with MDD: Diagnosis of MDD in last 60 months, but in full or partial remission in the last 8 weeks, as assessed with the Structured Clinical Interview for DSM-IV</p>	<p>MBCT: Followed standardized protocol (Segal et al., 2002). Focused on cultivating mindfulness or nonjudgmental present-moment awareness of mental content and everyday</p>	<p>Depressive symptoms, BDI: Difference in change in depressive symptom score (BDI) in MBCT vs. waitlist: SMD= -1.11, -2.07 to -0.15</p> <p>Response: NA</p>

<p>Purpose: To examine whether mindfulness meditation (MM) was associated with changes in objectively measured polysomnographic (PSG) sleep profiles and to relate changes in PSG sleep to subjectively reported changes in sleep and depression within the context of a randomized controlled trial.</p> <p>Country: United States</p> <p>Quality rating: Poor</p>	<p>Baseline depressive symptom score: <u>BDI</u> MBCT: 10.3 (6.2); Waitlist Control: 8.1 (4.8)</p> <p>Average age in years (SD): MBCT: 45.4 (7.1); Waitlist control: 48.1 (9.6)</p> <p>Gender: MBCT: 30.8% male; Waitlist Control: 12.5% male</p> <p>Inclusion criteria: Met the DSM-IV criteria for major depression in the last 60 months and had a lifetime history of at least three episodes but were in full or partial remission during the last 8 weeks with varying degree of residual symptoms. Partial remission defined as subjective symptom improvement, $HRSD_{24} \leq 20$, and the exclusion of individuals with severely depressed mood, severe anhedonia, or active suicidal ideation. Eligible participants reported difficulties with either sleep initiation, sleep maintenance, or early awakening, but not hypersomnia in the last 2 months.</p> <p>Exclusion criteria: History of bipolar disorder, cyclothymia, schizophrenia, schizoaffective disorder, persistent antisocial behavior, or repeated self-harm, borderline personality disorder, organic brain damage; current panic, obsessive compulsive disorder, eating disorder, or substance abuse/dependence; they could not read and write in English; they were receiving current psychotherapy; they already had a regular meditation practice; or they had taken antidepressant medication in the last 3 months. Participants were also excluded if they had or suspected an untreated sleep disorder besides insomnia.</p>	<p>activities, including sitting, lying down, breathing, walking, and other simple movements.</p> <p>Dosage: 8 weekly 3-hour sessions plus one-day retreat and home practice</p> <p>Co-interventions: None</p> <p>Comparator(s): Waitlist control, no intervention provided during wait time.</p> <p>Follow-up: At end of intervention</p>	<p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Study authors reported that there were no adverse events.</p> <p>Antidepressant use: NA</p>
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<p>Reference:: 2045 Chiesa et al., 2012</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To compare mindfulness-based cognitive therapy (MBCT) with a psycho-educational control group for the treatment of patients with major depression</p> <p>Country: Italy</p> <p>Quality rating: Fair</p>	<p>Number of participants: 18 initial, 16 final</p> <p>Method of identifying patients with MDD: Clinical diagnosis of MDD according to DSM-IV criteria</p> <p>Baseline depressive symptom score: <u>HRSD-21</u> MBCT: 16.11 (7.01) Control: 14.14 (4.98)</p> <p>Average age in years (SD): Not reported</p> <p>Gender: Overall: 25% male; MBCT: 22% male; Psycho-education: 29% male</p> <p>Inclusion criteria: Aged 18 years or over; meeting DSM-IV criteria for MDD, being on treatment with antidepressants at adequate dosages for at least 8 weeks, and a failure to achieve remission, defined as $HRSD_{21} \geq 8$.</p> <p>Exclusion criteria: Current or past psychosis, bipolar disorder, or substance abuse; severe physical or neurological conditions that could interfere with the engagement in mindfulness practices; and concurrent psychotherapy or engagement in any meditation or yoga practice.</p>	<p>MBCT: Followed standard manualized protocol (Segal et al., 2002)</p> <p>Dosage: 8 weekly 2 hour sessions. Encouraged home practice 30-45 minutes, 6x/week.</p> <p>Co-interventions: Antidepressants</p> <p>Comparator: Psychoeducation: Similar to MBCT but no emphasis on mindfulness skills. 8 weekly 2 hour sessions. Encouraged stretching or aerobic activity for 30-45 minutes, 6x week.</p> <p>Follow-up: At end of intervention</p>	<p>Depressive symptoms, HRSD-21: Difference in change in depressive symptom score (HRSD-21) in MBCT plus antidepressants vs. psychoeducation plus antidepressants: SMD = -0.81, -1.83 to 0.22</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life: Psychological General Well-Being Index (PGWBI): Difference in change in QOL score (PGWBI) in MBCT plus antidepressants vs. psychoeducation plus antidepressants: SMD=-0.81, -1.84 to 0.22</p> <p>Adverse events: Not reported</p> <p>Antidepressant use: NA</p>
<p>Reference: 2558 Godfrin et al., 2010</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To study the efficacy of MBCT in preventing relapse or recurrence in depression, in patients with a history of at least three depressive episodes but</p>	<p>Number of participants: 106 initial, 76 final</p> <p>Method of identifying patients with MDD: Past history of MDD according to DSM-IV criteria with at least 3 major depressive episodes and the most recent at least 8 weeks prior to study participation</p> <p>Baseline depressive symptom score: <u>BDI</u> MBCT: 17.59 (11.65); TAU + Waitlist: 20.44 (12.46)</p>	<p>MBCT: Followed standardized protocol (Segal et al., 2002) with aim to attend, non-judgmentally and moment-by-moment to patterns of thoughts, bodily sensations and feelings.</p> <p>Dosage: 8 weekly 2.75 hour sessions, at home exercises 6x/week for 45 minutes</p>	<p>Depressive symptoms, HRSD-17: <u>End of intervention</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU+waitlist: SMD=-0.98, -1.39 to -0.58</p> <p>8 Months: Difference in change in depressive symptom score in MBCT+TAU vs. TAU+waitlist at 8-month follow-up: SMD=-0.80, -1.19 to -0.40</p>

<p>who are currently in remission or recovery, its effect on the time since study participation until first relapse in depression, and short-term and longer-term effects on mood states and quality of life</p> <p>Country: Belgium</p> <p>Quality rating: Fair</p>	<p><u>HRSD₁₇</u> MBCT: 6.59 (3.99) TAU + Waitlist: 7.32 (3.65)</p> <p>Average age in years (SD): MBCT+TAU: 44.9 (10.78); Waitlist+TAU: 46.4 (10.37)</p> <p>Gender: MBCT+TAU: 17.3% male; Waitlist+TAU: 20.4% male</p> <p>Inclusion criteria: Aged 18 years or older and had a history of at least 3 depressive episodes according to DSM-IV-R criteria, the end of the last episode being at least 8 weeks before study participation. They did not suffer from a current depressive episode according to DSM-IV-R criteria, HRSD₁₇ ≤14.</p> <p>Exclusion criteria: Current DSM-IV-R diagnoses of chronic depression or dysthymia, substance use disorder, obsessive-compulsive disorder, bipolar disorder, acute psychosis, schizophrenia or schizoaffective disorder, cognitive disorder, organic mental disorder, pervasive developmental disorder, mental retardation, a primary diagnosis of an axis-II disorder or risk of suicide, or in cases of an extended experience with zen- or vipassana-meditation (or mindfulness) in the past. Finally, more than 1 psychiatric consultation per 3-4 weeks or intensive psychotherapy, or meditation practices other than MBCT during the training and/or follow up and physical problems, which hampered participation in the program, were considered exclusion criteria. Only patients living in a well-defined study region were included in order to prevent dropout due to geographical reasons.</p>	<p>Co-interventions: TAU</p> <p>Comparator(s): Waitlist control group continued TAU, which could include antidepressants and non-intensive psychotherapy</p> <p>Follow-up: At end of intervention, 8- and 14-month post-baseline</p>	<p><u>14 Months:</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU+waitlist at 14-month follow-up: SMD=-0.43, -0.82 to -0.05</p> <p>Depressive symptoms, BDI: <u>End of intervention:</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU+waitlist: SMD= -1.47, -1.90 to -1.04</p> <p><u>8 Month:</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU+waitlist at 8-month follow-up: SMD=-0.80, -1.19 to -0.40</p> <p><u>14 Months:</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU+waitlist at 14-month follow-up: SMD= -0.90, -1.29 to -0.50</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: Relapse in MBCT+TAU vs TAU + waitlist RR 0.45, 0.29 to 0.70</p> <p>Mean time to first relapse/recurrence since study participation: MBCT+TAU: 39.5 weeks Waitlist+TAU: 53.7 weeks Significant difference between</p>
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			<p>groups in mean time to first relapse ($p \leq .001$)</p> <p>Health-related quality of life: Quality of Life in Depression Scale</p> <p>Difference in change in HRQOL in MBCT+TAU vs. TAU + waitlist: SMD= -1.02, -1.42 to -0.61</p> <p><u>8 Months:</u> Difference in change in HRQOL in MBCT+TAU vs. TAU+waitlist at 8-month follow-up: SMD= -0.67, -1.06 to -0.28</p> <p><u>14 Months:</u> Difference in change in HRQOL in MBCT+TAU vs. TAU+waitlist at 14-month follow-up: SMD= -0.68, -1.07 to -0.29</p> <p>Adverse events: Not reported</p> <p>Antidepressant use:</p> <p><u>Baseline:</u> MBCT+TAU: $n=38$, 73.1% Waitlist+TAU: $n=33$ 61.1%</p> <p><u>End of intervention:</u> MBCT+TAU: $n=34$, 75.6% Waitlist+TAU: $n=29$ 60.4%</p> <p><u>8 Months:</u> MBCT+TAU: $n=27$, 64.3% Waitlist+TAU: $n=26$ 56.5%</p> <p><u>14 Months:</u> MBCT+TAU: $n=25$, 64.1% Waitlist+TAU: $n=28$ 62.2%</p>
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			No group*time significance reported.
<p>Reference: 2779 Hepburn et al., 2009</p> <p>Study design: Participants in remission or recovery with suicidality randomized to MBCT or waitlist control using stratification (suicidal history and past depressive episodes)</p> <p>Intention-to-treat analysis: No</p> <p>Purpose: To compare short-term effects of MBCT and treatment-as-usual on thought suppression (TS) in individuals with past suicidal depression.</p> <p>Country: United Kingdom</p> <p>Quality rating: Poor</p>	<p>Number of participants: 68 initial, 43 final</p> <p>Method of identifying patients with MDD: BDI</p> <p>Baseline depressive symptom score: BDI MBCT: 15.62 (13.84) TAU: 12.83 (9.59)</p> <p>Average age in years (SD): MBCT: 48.77 (9.04); TAU: 41.24 (9.00)</p> <p>Gender: 26.5% male</p> <p>Inclusion criteria: Had experienced both depression (minimum one episode) and suicidality (suicide attempt or severe ideation with a plan); met criteria for depression recovery.</p> <p>Exclusion criteria: Non-fluent English, receiving CBT without subsequent depressive relapse, and symptoms of substance misuse, psychosis or mania in the past 6 months.</p>	<p>MBCT: Program for suicidality, 2 hour weekly classes + 1 daylong session and daily homework</p> <p>Dosage: 8 weekly 2-hour sessions plus one-day retreat</p> <p>Co-interventions: Psychotherapy and medication</p> <p>Comparator(s): TAU: Including medication and any help-seeking during wait period.</p> <p>Follow-up: At end of intervention</p>	<p>Depressive symptoms, BDI: Difference in change in depressive symptom score (BDI) in MBCT+TAU vs. TAU SMD= -0.30, -0.91 to 0.30</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Not reported</p> <p>Antidepressant use: NA</p>
<p>Reference: 2250 Keune et al., 2011</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: No</p> <p>Purpose: To explore the psychological and psychophysiological effects of MBCT in recurrently depressed patients, especially the effect of MBCT on rumination and mindfulness as indicators of global cognitive style, as well as</p>	<p>Number of participants: 91 initial, 78 final</p> <p>Method of identifying patients with MDD: At least three past major depressive episodes, with the most recent episode in remission for at least 4 weeks. Assessed via the German version of the Structured Clinical Interview for DSM-IV.</p> <p>Baseline depressive symptom score: BDI MBCT: 9.05 (8.60) Waitlist control: 12.70 (9.19)</p> <p>Average age in years (SD): MBCT: 48.93 (9.68); Waitlist control: 45.24 (10.50)</p>	<p>MBCT: Followed standardized protocol (Segal et al., 2002)</p> <p>Dosage: 8 weekly sessions</p> <p>Co-interventions: TAU</p> <p>Comparator(s): Waitlist control: Advised to consult with their medical doctor or other sources of help if needed.</p> <p>Follow-up: At end of</p>	<p>Depressive symptoms, BDI: Difference in change in depressive symptom score (BDI) in MBCT+TAU vs. TAU + waitlist: SMD= -1.85, -2.38 to -1.31</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Not reported</p>

<p>on depressive symptomatology</p> <p>Country: Germany</p> <p>Quality rating: Poor</p>	<p>Gender: Overall: 26% male; MBCT: 25% male; WLC: 27% male</p> <p>Inclusion criteria: Ages 18 to 65; meet criteria for at least three MDE in the past; be in at least partial remission (defined as not meeting the minimum criteria for a MDE within the last 4 weeks); have stopped using medication at least 4 weeks prior to the interview; agree not to start medication during the course of the study, unless advised otherwise by a psychiatrist. If medicated, medication had to be stable for at least one month, and participants needed to agree not to change medication or dose during the course of therapy until the completion of the last EEG assessment, unless dose or type was recommended to be changed by a psychiatrist.</p> <p>Exclusion criteria: Not giving or withdrawing informed consent, presence or history of substance abuse, eating or obsessive-compulsive disorder during the last three years, a history of schizophrenia or schizoaffective disorder, any neurological disorder, and borderline personality disorder. Participants also were not included if they had ever practiced any form of meditation on a regular basis.</p>	<p>intervention</p>	<p>Antidepressant use: NA</p>
<p>Reference: 2935 Kuyken et al., 2008</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To examine whether mindfulness-based cognitive therapy (MBCT) provides an alternative approach to maintenance antidepressant</p>	<p>Number of participants: 123 initial, 104 final</p> <p>Method(s) of identifying patients with MDD: Clinical diagnosis of MDD in full or partial remission according to DSM-IV criteria</p> <p>Baseline depressive symptom score: <u>BDI-II</u> MBCT: 18.51(10.91) m-ADM: 20.15(12.86) <u>HRSD₁₇</u> MBCT: 5.62 (4.3)</p>	<p>MBCT: Followed standardized protocol (Segal et al., 2002). Content included guided mindfulness practices, inquiry into patients' experience of these practices, review of weekly homework, and teaching/ discussion of cognitive-behavioral skills. Plus support for tapering and discontinuation of ADM after 4-5 weeks of treatment.</p>	<p>Depressive symptoms, HRSD-17: <u>3 Months:</u> Difference in change in depressive symptom score (HRSD) in MBCT+ADM vs ADM at 3 months: SMD= -0.30, -0.66 to 0.05</p> <p><u>15 Months:</u> Difference in change in depressive symptom score in MBCT+ADM vs ADM at 15 months: SMD= -0.23, -0.58 to 0.13</p>

<p>medication (m-ADM) in preventing depressive relapse/recurrence and to compare MBCT and m-ADM in terms of residual depressive symptoms, comorbid psychiatric diagnoses, quality of life, and cost effectiveness</p> <p>Country: United Kingdom</p> <p>Quality rating: Fair</p>	<p>m-ADM: 5.76 (4.69)</p> <p>Average age in years (SD): MBCT: 48.95 (10.55); ADM: 49.37 (11.84)</p> <p>Gender: MBCT: 23%; m-ADM: 24%</p> <p>Inclusion criteria: Three or more previous episodes of depression meeting criteria for depression according to the DSM-IV; 18 years of age or older; and on a therapeutic dose of m-ADM in line with the British National Formulary for at least the previous 6 months and is in either full or partial remission from the most recent episode of depression.</p> <p>Exclusion criteria: Comorbid diagnoses of current substance dependence; organic brain damage; current/past psychosis; bipolar disorder; persistent antisocial behavior; persistent self-injury requiring clinical management/therapy; unable to engage with MBCT for physical, practical, or other reasons (e.g., very disabling physical problem, unable to comprehend materials); and formal concurrent psychotherapy.</p>	<p>Dosage: 8 weekly 2-hour sessions plus 4 follow-up sessions in the following year</p> <p>Co-interventions: Antidepressants tapered over course of MBCT</p> <p>Comparator(s): m-ADM: Patients' physicians were asked to manage m-ADM in line with standard clinical practice and ensure the dose remained within therapeutic limits.</p> <p>Follow-up: 3, 6, 9, 12, and 15 months after baseline</p>	<p>Depressive symptoms: BDI-II 3 Months: Difference in change in depressive symptom score in MBCT+ADM vs ADM at 3 months: SMD= -0.36, -0.72 to 0.00</p> <p>15 Months: Difference in change in depressive symptom score in MBCT+ADM vs ADM at 15 months: SMD= -0.33, -0.69 to 0.03</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse for ITT Analysis <u>Mean total # of relapses/ recurrences:</u> m-ADM 1.57 (95% CI: 1.32 to 1.81) MBCT 1.45 (95% CI: 1.21 to 1.69)</p> <p><u>Duration of relapses/ recurrences (in months):</u> m-ADM 3.0 (95% CI: 2.1 to 3.9) MBCT 3.36 (95% CI: 2.2 to 4.5)</p> <p><u>Severity of relapses/recurrences (DSM-IV severity specifier, 0-4):</u> m-ADM 1.72 (95% CI: 1.48 to 1.95) MBCT 1.79 (95% CI: 1.56 to 2.02)</p> <p>Relapse in MBCT+ADM vs ADM at 15 month follow-up RR 0.80, 0.57 to 1.11</p>
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			<p>Adverse events: Study authors reported that there were no adverse events recorded through the oversight of the Trial Steering Committee</p> <p>Antidepressant costs: Mean difference of MBCT vs m-ADM (95% CI): -\$103 (-\$191, -\$14)</p>
<p>Reference: 3384 Ma and Teasdale, 2004</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To compare response to MBCT in a group of patients with three or more episodes of depression versus a group with only two (recent) episodes</p> <p>Country: United Kingdom</p> <p>Quality rating: Good</p>	<p>Number of participants: 75 initial, 68 final</p> <p>Method of identifying patients with MDD: History of recurrent MDD according to DSM-IV criteria, currently in remission or recovery</p> <p>Baseline depressive symptom score: <u>BDI</u> MBCT: 13.49 (7.16) TAU: 15.13 (9.51) <u>HRSD₁₇</u> MBCT: 5.70 (3.02) TAU: 5.68 (2.97)</p> <p>Average age in years (SD): MBCT 42.9 (8.4); TAU: 46.1 (9.3)</p> <p>Gender: MBCT: 27% male; TAU: 21% male</p> <p>Inclusion criteria: (a) being 18–65 years of age;(b) meeting enhanced <i>DSM-IV</i> criteria for a history of recurrent major depression—these normally require a history of two or more previous episodes of <i>DSM-IV</i> major depression in the absence of a history of mania or hypomania; required, further that (i) at least two episodes of major depression occurred within the past 5 years and (ii) at least one of those episodes was within the past 2 years; (c) having a</p>	<p>MBCT: Followed standardized protocol (Segal et al., 2002).</p> <p>Dosage: 8 weekly 2-hour sessions plus daily homework; follow-up meetings 1 and 6 months after intervention</p> <p>Co-interventions: TAU</p> <p>Comparator(s): TAU: Instructed to seek help as usual</p> <p>Follow-up: At the end of the intervention and 3-, 6-, 9- and 12-months post-intervention</p>	<p>Depressive symptoms: NA</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: Full sample (2+ previous MD episodes) in ITT sample: Relapse in MBCT+TAU vs TAU: RR 0.63, 0.39 to 1.01</p> <p>2 previous MD episodes in the ITT sample: Relapse in MBCT+TAU vs TAU: RR 2.50, 0.60 to 10.34</p> <p>3 or more previous MD episodes in the ITT sample: Relapse in MBCT+TAU vs TAU: RR 0.46, 0.27 to 0.79</p> <p>Health-related quality of life:</p> <p>Adverse events: Not reported</p> <p>Antidepressant use during study period: 2 previous MD episodes MBCT+TAU: 13%; TAU: 36%;</p>

	<p>history of treatment by a recognized antidepressant medication, but being off antidepressant medication and in recovery/remission at the time of baseline assessment and for at least the preceding 12 weeks; and (d) having, at baseline assessment, a HSRD₁₇<10.</p> <p>Exclusion criteria: History of schizophrenia or schizoaffective disorder, current substance abuse, borderline personality disorder, organic mental disorder or pervasive developmental delay, current obsessive-compulsive disorder, current eating disorder, dysthymia before age 20, more than four lifetime sessions of CBT, and current psychotherapy or counseling more frequently than once per month.</p>		<p>p>0.10 3 or more previous MD episodes MBCT+TAU: 21%; TAU: 33%; p>0.10</p> <p>Duration in weeks 2 previous MD episodes MBCT+TAU: 27.0 (0); TAU: 27.5 (14.5) p>0.10 3 or more previous MD episodes MBCT+TAU: 25.4 (8.2); TAU: 34.6 (20.2) p>0.10</p> <p>Dosage SSI (mg) 2 previous MD episodes MBCT+TAU: 26.7 (0); TAU: 22.5 (5.0) p>0.10 3 or more previous MD episodes MBCT+TAU: 27.0 (5.4); TAU: 23.6 (8.9)</p>
<p>Reference: 2225 Manicavasgar et al., 2011</p> <p>Study design: Participants in 8 of the 11 treatment groups were randomly assigned to the CBT or MBCT condition. 3 of the 11 treatment groups were run according to therapist availability and group participants were assigned sequentially.</p> <p>Intention-to-treat analysis: No</p> <p>Purpose: To examine the comparative effectiveness of</p>	<p>Number of participants: 69 initial, 45 final</p> <p>Method of identifying patients with MDD: Met DSM-IV criteria for MDD as assessed by the computerized version of the Composite International Diagnostic Interview (CIDI-AUTO)</p> <p>Baseline depressive symptom score: <u>BDI-II</u> MBCT: 32.42 (9.01) CBT: 36.23 (11.11)</p> <p>Average age in years (SD): MBCT: 47 (13.84); 45 (12.94)</p> <p>Gender: MBCT: 37% male; CBT: 34% male</p>	<p>MBCT: Modified MBCT protocol (Segal et al., 2002). Yoga instruction and DVD-based “Mindfulness-Based Stress Reduction” program were omitted. Purchase of program book made optional rather than compulsory.</p> <p>Dosage: 8 week course, 2-2.5 hour group 1x/week plus home practice</p> <p>Co-interventions: TAU</p> <p>Comparator: CBT based on standardized protocol (Beck et</p>	<p>Depressive symptoms, BDI-II: <u>Post-intervention</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU: SMD= -0.15, -0.74 to 0.44</p> <p><u>6 Months:</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU at 6 months: SMD= 0.70, -0.26 to 1.65</p> <p><u>12 Months:</u> Difference in change in depressive symptom score in MBCT+TAU vs. TAU at 15 months: SMD= 0.18, -0.58 to 0.93</p>

<p>Mindfulness-Based Cognitive Therapy (MBCT) and Cognitive Behavior Therapy (CBT) as treatments for non-melancholic depression</p> <p>Country: Australia</p> <p>Quality rating: Poor</p>	<p>Inclusion criteria: Aged 18 years or over; meeting DSM-IV criteria for major depressive disorder on the computerized version of the Composite International Diagnostic Interview (CIDI-AUTO); BDI-II\geq20 at telephone screening; reporting low mood for at least three preceding months; being proficient in English; not having engaged in CBT, mindfulness or meditation/relaxation (operationalized as more than four sessions of regular meditation/relaxation) over the preceding 12 months; being under supervision of a case manager/clinician; not commencing antidepressant medication or, if medicated, not changing their antidepressant medication regime over the preceding three months; and preparedness to commit to an 8-week group program.</p> <p>Exclusion criteria: Current diagnosis of melancholic depression or bipolar disorder; a history of any psychotic illness; dementia; current active suicidal ideation; being hospitalized; concurrent treatment using meditation or CBT; drug/alcohol dependence; daytime anxiolytic medication (which could potentially impair concentration); current antenatal or postnatal depression (which could be related to hormonal factors); currently in receipt of antipsychotic or mood stabilizing medication; and history of treatment with more than two antidepressant drugs.</p>	<p>al., 1979), 8 weekly 2-2.5 hours sessions plus home practice</p> <p>Follow-up: At end of intervention, 6 and 12 months post-intervention</p>	<p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life: SOFAS Difference in change in HRQOL score in MBCT+TAU vs. CBT: -0.04, -0.63 to 0.56</p> <p>Adverse events: Not reported</p> <p>Antidepressant use: NA</p>
<p>Reference: 1477 Omid et al., 2013</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: N/A, no drop out</p> <p>Purpose: To evaluate the efficacy of Mindfulness Based</p>	<p>Number of participants: 90 initial, 90 final</p> <p>Method of identifying patients with MDD: Clinical diagnosis of MDD</p> <p>Baseline depressive symptom score: <u>BSI, depression subscale</u> MBCT: 2.05(0.84) CBT: 2.18 (0.57) TAU: 2.18(0.85)</p>	<p>MBCT: Standardized MBCT program (Segal, Williams, and Teasdale, 2002) with the addition of behavioral enhancement components of CBT for depression.</p> <p>Dosage: 8 2-hour sessions, 1x/week</p>	<p>Depressive symptoms, BSI Depression Scale: Difference in change in depressive symptom score in MBCT+TAU vs. TAU: SMD= -1.53, -2.11 to -0.96</p> <p>Difference in change in depressive symptom score in MBCT+TAU vs. CBT+TAU: SMD= -0.00, -0.51 to -0.51</p>

<p>Cognitive Therapy (MBCT) and traditional Cognitive Behavior Therapy (CBT) with treatment as usual (TAU) to reduce psychiatric symptoms in a sample of patients with MDD</p> <p>Country: Iran</p> <p>Quality rating: Poor</p>	<p>Average age in years (SD): MBCT: 32 (6.3); CBT: 30 (5.2); TAU: 35 (4.8)</p> <p>Gender: MBCT: 20% male; CBT: 34% male; TAU: 47% male</p> <p>Inclusion criteria: Meet DSM-IV criteria for MDD</p> <p>Exclusion criteria: BMD (acronym undefined), psychosis, drug abuse, organic history, eating disorder, and suicidality</p>	<p>Co-interventions: Usual care</p> <p>Comparators (2): CBT: Standardized treatment protocol developed by Emery (2000) TAU: Continued under the care of a therapist and/or psychiatrist.</p> <p>Follow-up: At end of intervention</p>	<p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life:</p> <p>Adverse events: Not reported</p> <p>Antidepressant use: NA</p>
<p>Reference: 2441 Segal et al., 2010</p> <p>Study design: 2 stage study Stage 1: acute treatment of depression with antidepressants Stage 2: Among stage 1 participants who remitted, RTC with 3 arms (1) maintenance of antidepressant monotherapy (M-ADM), (2) discontinuation of antidepressant and addition of mindfulness-based cognitive therapy (MBCT), (3) discontinuation of antidepressant, substitution with placebo pills and clinical management (Pla + Clin)</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To test the relative efficacy of MBCT, maintenance antidepressant monotherapy (M-ADM), and placebo plus clinical management for prevention of relapse or recurrence in patients</p>	<p>Number of participants: 84 initial, 64 final</p> <p>Method of identifying patients with MDD: Prior to stage 1, diagnosis of MDD as assessed with the Structured Clinical Interview for DSM-IV</p> <p>Baseline depressive symptom score: <u>HRSD-17</u> M-ADM: 2.0 (2.3) MBCT: 3.0 (2.8) Pla + Clin: 3.3 (3.0) <u>QIDS:</u> M-ADM: 3.0 (1.7) MBCT: 3.4 (2.4) Pla + Clin: 2.9 (2.3)</p> <p>Average age in years (SD): Overall: 44 (11); M-ADM: 45.8 (11.4); MBCT: 44.8 (9.4); Pla+Clin: 41.9 (11.6)</p> <p>Gender: Overall: 42% male; M-ADM: 29% male; MBCT: 50% male; Pla+Clin: 33% male</p> <p>Inclusion criteria: Diagnosis of MDD according to DSM-IV criteria; a score of 16 or higher on the HRSD₁₇; 2 or more previous episodes of MDD (to ensure that those randomized would have a</p>	<p>MBCT: Followed standardized protocol (Segal et al., 2002). Antidepressants discontinued via 4-week taper.</p> <p>Dosage: 8 weekly 2-hour sessions plus a retreat and daily at home exercises</p> <p>Co-interventions: Bimonthly meetings with study psychiatrists</p> <p>Comparator(s): 2 comparison groups: (1) M-ADM: Remained on same drug regimen at maximum tolerated effective dose. (2) Plac + Clin: Patients tapered off antidepressant with placebo replacements, plus clinical management.</p> <p>Follow-up: At the end of the intervention, monthly for the next 3months, and bimonthly</p>	<p>Depressive symptoms: NA</p> <p>Response: NA</p> <p>Remission Relapse: SCID (assessing relapse): (their score subsequent to an elevation was 7 or less the range of elevated scores fell between 8 and 14):</p> <p><u>At 18 Months Follow-Up:</u> Relapse in MBCT vs ADM: RR 0.80, 0.39 to 1.62</p> <p>Relapse in MBCT and clinical management vs placebo and clinical management RR: 0.65, 0.34 to 1.62</p> <p><u>Of the stable remitters</u> (maintained an HRSD-17 score of 7 or less across this interval): Relapse in MBCT vs ADM: RR 1.06, 0.54 to 2.07</p> <p>Relapse in MBCT and clinical</p>

<p>with recurrent depression who have achieved remission through antidepressant pharmacotherapy</p> <p>Country: Canada</p> <p>Quality rating: Fair</p>	<p>minimum of 3 past episodes); age between 18 and 65 years, and English speaking and the ability to provide informed consent.</p> <p>Exclusion criteria: Current diagnosis of bipolar disorder, substance abuse disorder, schizophrenia, or borderline or antisocial personality disorder; a trial of electroconvulsive therapy within the past 6 months; depression secondary to a concurrent medical disorder; current or planned pregnancy within the 6 months of acute-phase treatment; and current practice of meditation more than once per week or yoga more than twice per week.</p>	<p>for the remainder of the 18-month maintenance phase</p>	<p>management vs placebo and clinical management RR: 1.25, 0.54 to 2.07</p> <p><u>In unstable remitters:</u> (had occasional elevated scores across this Interval): Relapse in MBCT vs ADM: RR 1.02, 0.30 to 3.45</p> <p>Relapse in MBCT and clinical management vs placebo and clinical management RR: 0.39, 0.17 to 0.88</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Not reported</p> <p>Antidepressant use: NA</p>
<p>Reference: 2437 Shahar et al., 2010</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: No</p> <p>Purpose: To examine the immediate (pre-to-post intervention) effects of MBCT on reductions in depressive symptoms</p> <p>Country: United States</p> <p>Quality rating: Poor</p>	<p>Number of participants: 52 initial, 45 final</p> <p>Method of identifying patients with MDD: Diagnosis of MDD in the past 60 months, with lifetime history of at least 3 episodes, as assessed by the structured clinical interview for DSM-IV. In partial remission in last 2 months.</p> <p>Baseline depressive symptom score: <u>BDI</u> MBCT: 9.10 (6.10) Waitlist Control: 10.16 (6.20)</p> <p>Average age in years (SD): MBCT: 46.58 (7.77); WLC: 46.74 (11.70)</p> <p>Gender: MBCT: 23.08% male; WLC: 5.26% male</p> <p>Inclusion criteria: Met <i>DSM-IV</i> criteria for major depression in the last 60 months and had a lifetime</p>	<p>MBCT: Followed standardized protocol (Segal et al., 2002). Sessions focused on cultivating mindfulness or nonjudgmental present-moment awareness of mental content and everyday activities, including sitting, lying down, breathing, walking, and other simple movements.</p> <p>Dosage: 8 weekly 3-hour sessions plus a one-day retreat and at home practice</p> <p>Co-interventions: TAU</p> <p>Comparator(s): Waitlist control group</p>	<p>Depressive symptoms, BDI: Difference in change in depressive symptom score (BDI) in MBCT+TAU vs. TAU+waitlist: SMD= -1.14, -1.78 to -0.51</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Authors reported that there were no adverse events during the trial.</p> <p>Antidepressant use: NA</p>

	<p>history of at least 3 episodes, but were in partial remission during the last 8 weeks with a varying degree of residual symptoms. Partial remission was defined by a subjectively reported improvement in symptoms in the last 2 months, $HRSD_{24} \leq 20$ and the exclusion of severely depressed mood, severe anhedonia or active suicidal ideation. No change in antidepressant type or dose during the 3 months prior to enrollment or during the active phase of the study.</p> <p>Exclusion criteria: History of bipolar disorder, cyclothymia, schizophrenia, schizoaffective disorder, persistent antisocial behavior or repeated self-harm, borderline personality disorder, organic brain damage; current panic, obsessive-compulsive disorder, eating disorder, or substance abuse/dependence; they could not read and write in English; receiving current psychotherapy; already had a regular meditation practice.</p>	Follow-up: At end of intervention	
<p>Reference: 3564 Teasdale et al., 2000</p> <p>Study design: Multisite (3) RCT. Patients randomized to MBCT + TAU or TAU + WLC at three sites. Randomization stratified by "recency of recovery from last episode of depression and number of previous episodes of MDD"</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To evaluate mindfulness-based cognitive therapy (MBCT) as a mediator for relapse/recurrence</p> <p>Country: Canada/United</p>	<p>Number of participants: 145 initial, 137 final</p> <p>Method of identifying patients with MDD: $HRSD-17 \leq 10$, BDI, Clinical diagnosis</p> <p>Baseline depressive symptom score: NA</p> <p>Average age in years (SD): MBCT: 40.7 (10.3); TAU: 46.2 (9.6)</p> <p>Gender: MBCT: 26% male; TAU: 22% male</p> <p>Inclusion criteria: 18 to 65 years of age; meeting enhanced DSM-III criteria for a history of recurrent major depression (these normally require a history of two or more previous episodes of DSM-III major depression in the absence of a history of mania or hypomania; in addition, we required that at least two episodes of major depression occurred within the past 5 years and</p>	<p>MBCT: Manualized 2 hour weekly sessions + daily homework, weekly for first eight weeks, and monthly for final 4 sessions.</p> <p>Dosage: 12 sessions</p> <p>Co-interventions: Care from general practitioner, psychiatric treatment (out/inpatient), counseling, medication</p> <p>Comparator(s): TAU: Instructed to seek help as needed</p> <p>Follow-up: Bimonthly for 1 year</p>	<p>Depressive symptoms: NA</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: <u>2 episodes of depression (23% of sample)</u> Relapse in MBCT+TAU vs TAU: RR 1.80, 0.77 to 4.19 <u>3 or more episodes of depression (77% of sample)</u> Relapse in MBCT+TAU vs TAU: RR 0.61, 0.41 to 0.89</p> <p>Health-related quality of life: NA</p> <p>Adverse events: Not reported</p>

<p>Kingdom</p> <p>Quality rating: Good</p>	<p>that at least one of those episodes was within the past 2 years); a history of treatment by a recognized antidepressant medication, but off antidepressant medication, and in recovery/remission, at the time of baseline assessment and for at least the preceding 12 weeks (it was not possible to determine the adequacy of treatment by antidepressant medication; rather, this criterion was used as an indicator that, in the naturalistic course of service delivery, patients had been judged as appropriate for pharmacotherapy by a treating physician); and at baseline assessment, a 17-item HRSD score ≤ 10.</p> <p>Exclusion Criteria: History of schizophrenia or schizoaffective disorder; current substance abuse, eating disorder, or obsessive compulsive disorder (OCD); organic mental disorder, pervasive developmental delay, or borderline personality disorder (BPD); dysthymia before age 20; more than four sessions of cognitive-behavioral treatment ever; current psychotherapy or counseling more frequently than once per month; and current practice of meditation more than once per week or yoga more than twice per week.</p>		<p>Antidepressant use: MBCT: 40% TAU: 45% p=0.10</p>
<p>Reference: 1770 Van Aalderen et al., 2012</p> <p>Study design: Single site RCT</p> <p>Intention-to-treat analysis: Yes</p> <p>Purpose: To examine the efficacy of mindfulness-based cognitive therapy (MBCT) in a representative sample of patients with recurrent depression; to examine whether MBCT was effective for patients with or without a current depressive</p>	<p>Number of participants: 219 initial, 205 final</p> <p>Method of identifying patients with MDD: Recurrent depression according to the Structural Clinical Interview for DSM-IV</p> <p>Baseline depressive symptom score: <u>HRSD₁₇</u> MBCT+TAU: 9.5 (6.2) TAU: 9.2 (5.6) <u>BDI</u> MBCT+TAU: 14.9 (9.2) TAU: 16.2 (9.4)</p> <p>Average age in years (SD): MBCT: 47.3 (11.5);</p>	<p>MBCT: MBCT was delivered according to guidelines (Segal et al., 2002).</p> <p>Dosage: 9 sessions, 8 weekly 2.5 hour sessions and a silent day of 6 hours of meditation. Home practice 6x/week for 45 minutes.</p> <p>Co-interventions: TAU</p> <p>Comparator: TAU, including antidepressants</p>	<p>Depressive symptoms, HRSD-17 Full sample: Difference in change in depressive symptom score in MBCT+TAU vs. TAU: SMD= -0.47, -0.75 to -0.20 Currently depressed subgroup: Difference in change in depressive symptom score in MBCT+TAU vs. TAU: SMD= -0.43, -0.71 to -0.15</p> <p>Depressive symptoms: BDI Full sample: Difference in change in depressive symptom score in MBCT+TAU vs. TAU: SMD= -0.03, -0.30 to 0.25</p>

<p>episode; and to investigate rumination, worry and mindfulness skills as possible mediators for the reduction of depressive symptoms in the MBCT condition</p> <p>Country: Netherlands</p> <p>Quality rating: Poor</p>	<p>TAU: 47.7 (11.1)</p> <p>Gender: MBCT: 30% male; TAU: 28% male</p> <p>Inclusion criteria: Three or more previous depressive episodes according to DSM-IV criteria. Patients using antidepressant medication were required to be on a stable dose for at least 6 weeks and were asked to maintain this dosage for the study period.</p> <p>Exclusion criteria: Any previous (hypo)manic episodes according to DSM-IV criteria ; current alcohol or drug abuse; urgent need for psychiatric treatment, for example, suicidality or psychotic symptoms; problems impeding participating in a group, such as severe borderline personality disorder; problems impeding completing the questionnaires, such as cognitive dysfunctions.</p>	<p>Follow-up: At end of intervention</p>	<p>Currently depressed group Difference in change in depressive symptom score in MBCT+TAU vs. TAU: SMD= -0.63, -0.91 to -0.35</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse: NA</p> <p>WHOQOL-Brief Physical Full sample Difference in change in physical HRQOL score in MBCT+TAU vs. TAU: SMD= -0.38, -0.66 to -0.11</p> <p>Currently depressed subsample Difference in change in physical HRQOL score in MBCT+TAU vs. TAU: SMD= -0.17, -0.44 to 0.11</p> <p>WHOQOL-Brief Psychological Full sample Difference in change in psychological HRQOL score in MBCT+TAU vs. TAU: SMD= -0.42, -0.70 to -0.14</p> <p>Currently depressed subsample Difference in change in psychological HRQOL score in MBCT+TAU vs. TAU: SMD= -0.49, -0.77 to -0.21</p> <p>WHOQOL-Brief Social Full sample Difference in change in social HRQOL score in MBCT+TAU vs. TAU: SMD= -0.09, -0.36 to 0.18</p> <p>Currently depressed subsample Difference in change in social</p>
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			<p>HRQOL score in MBCT+TAU vs. TAU: SMD= -0.26, -0.53 to 0.02</p> <p>Adverse events: Not reported</p> <p>Antidepressant use: NA</p>
<p>Reference: 1365 Williams et al., 2014</p> <p>Study design: Multisite RCT</p> <p>Intention-to-treat analysis: No</p> <p>Purpose: To compare mindfulness-based cognitive therapy (MBCT) with both cognitive psychological education (CPE) and treatment as usual (TAU) in preventing relapse to major depressive disorder (MDD) in people currently in remission following at least 3 previous episodes, using time to relapse to major depression as the main outcome</p> <p>Country: United Kingdom</p> <p>Quality rating: Poor</p>	<p>Number of participants: 274 initial, 255 final</p> <p>Method of identifying patients with MDD: Diagnosis of MDD currently in remission as assessed with the Structured Clinical Interview for DSM-IV</p> <p>Baseline depressive symptom score: <u>HRSD</u> MBCT: 3.17 (3.61) CPE: 3.55 (3.50) TAU: 2.57 (3.47) <u>BDI</u> MBCT: 7.72 (6.68) CPE: 8.86 (9.27) TAU: 7.05 (6.94)</p> <p>Average age in years (SD): 43 (12)</p> <p>Gender: 28% male</p> <p>Inclusion criteria: Age between 18 and 70 years; history of at least three episodes of major depression meeting DSM-IV criteria, of which two must have occurred within the last 5 years, and one within the last 2 years; remission for the previous 8 weeks (with potential trial participants deemed not to be in recovery or remission, and hence ineligible, if they reported that at least 1 week during the previous 8 they experienced either a core symptom of depression (depressed mood, anhedonia) or suicidal feelings and at least one other symptom of depression, which together were not attributable to bereavement, substances, or</p>	<p>MBCT: Manualized group skills training program (Segal, Williams, and Teasdale, 2002) that integrates psychological educational aspects of CBT for depression with meditation components of mindfulness-based stress reduction. Followed MBCT manual except for greater emphasis on factors that might be associated with suicidal planning and actions</p> <p>Dosage: 8 weekly 2-hour classes + 2 follow-up classes</p> <p>Co-interventions: Encouraged participants to continue current medication and attend their mental health practitioners or other services as usual during the trial (TAU)</p> <p>Comparators (2): CPE: Manualized MBCT program excluding the experiential cultivation of mindfulness through meditation practice.</p> <p>TAU: Not specified, but therapist stressed the importance seeking treatment</p>	<p>Depressive symptoms:</p> <p>Response: NA</p> <p>Remission: NA</p> <p>Relapse (meeting relevant SCID criteria for at least 2 weeks since previous assessment): Relapse in MBCT+TAU vs TAU: RR 0.88, 0.63 to 1.22</p> <p>Relapse in MBCT+TAU vs CPE+TAU: RR 0.93, 0.70 to 1.24</p> <p>Health-related quality of life: NA</p> <p>Adverse events: 15 SAEs reported to research team (MBCT=5, CPE=10).</p> <p>Only 1 “serious adverse reaction” potentially arising from a trial treatment— an episode of serious suicidal ideation following discussion of different coping responses to low mood in CPE. 14 overnight admissions 13 for physical health problems and 1 following an overdose during follow-up in a patient who had received MBCT. 1 participant died from an unrelated medical condition after partially</p>

	<p>medical condition, but were impairing functioning); informed consent from participants and their primary care physicians.</p> <p>Exclusion criteria: History of schizophrenia, schizoaffective disorder, bipolar disorder, current abuse of alcohol or other substances, organic mental disorder, pervasive developmental delay, primary diagnosis of obsessive-compulsive disorder or eating disorder, or regular nonsuicidal self-injury; positive continuing response to cognitive behavior therapy (CBT), that is, no relapse to depression since treatment with CBT, due to the known effects of CBT in reducing risk of relapse; current psychotherapy or counseling more than once a month; regular meditation practice (meditating more than once per month); or inability to complete research assessments through difficulty with English, visual impairment, or cognitive difficulties.</p>	<p>as needed.</p> <p>Follow-up: At the end of the intervention and 3, 6, 9 and 12 months post-intervention</p>	<p>withdrawing from trial follow-up due to illness.</p> <p>Antidepressant use: NA</p>
<p>Note: ADM= antidepressant medication; BDI= Beck Depression Inventory; BSI= Brief Symptom Inventory; CBT= cognitive behavior therapy; CES-D= Center for Epidemiologic Studies Depression Scale 10; CI=confidence interval; CIDI-AUTO=Composite International Diagnostic Interview; CPE=cognitive psychological education; DSM-III=Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition; DSM-IV=Diagnostic and Statistical Manual of Mental Disorders, 4th Edition; DSM-IV-R= Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Revised; EEG= electroencephalogram; GAS=Geriatric Anxiety Scale; HRSD=Hamilton Rating Scale for Depression; ICD-10 = International Classification of Diseases -10; ITT=Intention-to-treat; M-ADM =monotherapy antidepressant medication; MADRS=Montgomery-Asberg Depression Rating Scale; MBCT= mindfulness-based cognitive therapy; MDD=major depressive disorder; PPT=per protocol treatment; QIDS=Quick Inventory of Depressive Symptomatology; QoL=quality of life; RCT= randomized controlled trial; SCID=Structured Clinical Interview for DSM-IV; SOL=Sleep Onset Latency; TAU=treatment as usual; WHOQOL= World Health Organization Quality of Life Instrument; WHOQOL-BREF= World Health Organization Quality of Life Instrument-Brief; WLC=waitlist control</p>			



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